King Edward's Hospital Fund for London
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Homelessness

What can the health service do?

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ISBN 1 85717 043 1

INTRODUCTION

There is little doubt that homelessness is bad for the health of the nation. Action is needed from the government to tackle the housing shortage and increase the supply of affordable housing. Homelessness is a major cause of preventable ill-health and should therefore be of concern to NHS service planners and providers. Homeless people experience poor access both to primary and secondary care.

HEALTH PROBLEMS OF HOMELESS PEOPLE

Recent research has found that homeless people are 2.5 times as likely to suffer from a long-term illness as other people of a similar age in the general population[1]. Unplanned admission rates to hospital are also two or three times greater among the homeless than the rest of the resident population[2].

Homelessness affects different groups in different ways:

Children

Living in a cramped space such as a hotel room can restrict the growth and development of children. Studies have shown that children living in temporary accommodation suffer both emotionally and educationally. They show a high incidence of depression, disturbed sleep, poor eating, overactivity, bedwetting and soiling, toilet training problems, and aggression (Shelter research paper, 1987). Other research has indicated that they are at higher risk of suffering from accidents, behavioural problems and infectious disease. There are some examples of malnutrition[3,4].

People living on the streets or in very temporary accommodation

These people are at increased risk of injury, respiratory problems including tuberculosis, infection and infestation[5]. People working with homeless people have noticed the recurrence of trench foot, caused by the constant wearing of trainers and boots[6]. This group may also be involved with prostitution and intravenous drug use and, where they take chances, they increase the risk of becoming HIV positive.

Hostels for homeless people give shelter to people with a range of disabilities and illnesses. Arlington House in North London estimates that out of 391 tenants at least 70 are mentally ill, more than 100 have chronic alcohol problems, and 30 are active drug users. Around 55 elderly men live in the hostel – two thirds of whom have a physical disability.

Women

Women who are pregnant when they move into temporary accommodation are likely to have problems during pregnancy and delivery and their babies are more likely to have a low birth weight[7,8]. A study carried out in the Department of Obstetrics at St Mary's Hospital in London found that homeless women were more likely than other local women to be younger, have later booking dates, to smoke more and have a history of previous stillbirth[9]. It can be difficult for women living in bed and breakfast accommodation to get enough sleep because of overcrowding, and to eat a healthy diet, because they do not have access to cooking facilities or refrigerators to keep food fresh.

Mentally ill people

Having a mental illness can cause homelessness, but being homeless may also be the cause of poor mental health – for example, depressive illness. A survey by Riverside Health Authority found much higher levels of mental illness among homeless people than among the general population, but the study did recognise the difficulty of separating out factors like poverty and unemployment from homelessness itself.

Poor quality temporary accommodation

Accommodation is often damp, mouldy, overcrowded, dangerous for play and lacking in cooking and laundry facilities – which may lead directly to health problems.

HOW BIG IS THE PROBLEM OF HOMELESSNESS?

Homelessness is not a passing phenomenon. It has been increasing and is likely to be an issue for health authorities for a long time to come.

In 1990, a record number of 45,270 households in England was recognised as homeless by their local authority. Official figures do not tell us the number of homeless individuals but this has been estimated as 406,000[9].

There are many reasons why there is not enough housing and much has been written about the increasing demands on, and the decreasing supply of, housing. One reason is the fall in the number of council houses being built. In England and Wales, there was a decline from 112,000 local authority dwellings completed in 1977 to 6,000 in 1991/92. Other factors have also contributed to the problem[10].

The current crisis can be traced back to the 1970s and even earlier[11], and it seems unlikely to disappear in the near future. There is so much ground to be made up that even if the government were committed to a rejuvenation of housing across all sectors, there would still be substantial numbers of homeless people for many years to come.

Groups of people who are homeless include: families living in local authority temporary accommodation, particularly bed and breakfast and leased accommodation; single homeless

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people, sleeping rough or staying in hostels, hotels and squats; and young homeless people, the numbers of whom are growing and who have often been in care up to the age of 16. Black people and women are disproportionately represented among homeless people.

SERVICES FOR HOMELESS PEOPLE – SHOULD THEY BE SEPARATE FROM OTHER SERVICES IN THE NHS OR AN INTEGRATED PART OF THE WHOLE?

Many of the early experiments in providing services for homeless people involved appointing either lone specialist workers or specialist teams, which were additional to existing services and not an integrated part of mainstream services.

Examples include:

- **lone health visitors** appointed to work with families in bed and breakfast accommodation. Problems with this approach were detected early on, with many workers suffering from overwork and stress and some health visitors being forced to quit because of 'burn-out'.
- **mobile services,** designed to take services to where people lived. One example was a mobile clinic run from a caravan in Hackney, which took a limited range of primary care services to homeless families in the area. Since a high proportion of homeless families were from Bangladesh, a Bengali-speaking health advocate was employed, along with a health visitor, a woman doctor and a clerk.
- **specialist teams,** such as those set up in 1986 by the Department of Health in East London and Camden. The composition of the team in East London included a salaried GP, an alcohol counsellor, a community psychiatric nurse, social workers and a project co-ordinator. In Camden, the team was a salaried doctor, a nurse and a co-ordinator.

Advantages of such schemes:

- they provide a service to some people who would otherwise go without health care;
- a team approach recognises that homeless people have a range of inter-related problems;
- they can be an entry point into mainstream provision and help change the attitudes of GPs and other health professionals towards homeless people;
- they are popular with users.

There are, however, strong disadvantages to such segregated, specialist services, such as:

- they are often temporary, with uncertainties about what will happen when their funding expires;
- because they are not integrated into mainstream provision, they only provide a limited range of services and do not provide emergency out-of-hours cover. They also have no obvious way to influence the rest of the local health service. As the project Access to Health said: 'Although setting up a specialist service clearly ensures primary health care for [homeless people] it is also possible that it creates a "poor service for poor people", ie, a service that does not have the links and advantages of a mainstream service. It can therefore "institutionalise inequalities"';
- the schemes may not provide adequate support for team members, who often feel professionally isolated. Since the work is highly demanding, turn-over of staff members is frequently high and regular recruitment of committed individuals is therefore required;
- provision of such specialist teams is a convenient conscience-salver for others working in the NHS, who feel that the job of looking after homeless people is being done, and that they therefore have no obligation to do anything.

Many of the staff on these specialist teams understood the dilemma of providing a separate service, and aimed from the start to increase homeless people's use of mainstream services. Yet this proved difficult because of the inherent problem of providing a good service and then persuading people to use another one.

For these reasons, the King's Fund believes that the most effective way of delivering health care to homeless people is to provide an integrated service, although special arrangements will often be required to ensure access.

PROVIDING AN INTEGRATED SERVICE

Since the gateway to almost all NHS services is the GP, improving access for homeless people to family doctors is a crucial first step.

Many homeless people, however, are not registered with a GP. A survey, carried out by the Simon Community, of homeless people living on the streets of London[12], found that only 28 per cent were registered with a GP, and half of these were inappropriately registered with doctors outside London. Most of them had not consulted their GP within five years.

While registration is much higher among families[13] they, too, are frequently registered with GPs miles from their temporary address.

Homeless people are frequent users of accident and emergency departments. Such a situation is inherently unsatisfactory, because such departments are not geared up to addressing primary health care problems and do not carry out any preventive work, such as immunisations, cervical smears, blood pressure checks or dietary and smoking advice.

WHY ARE SO FEW HOMELESS PEOPLE REGISTERED WITH A GP?

Research has shown that for many homeless people registering with a GP is a low priority[14]. Some, for example, feel that registering is a waste of time given their mobility and the uncertainty about where they will be living in the near future. Other reasons for not registering appear to be low expectations about their health and previous poor experience of contact with the health service.

Some homeless people who try to register with a GP find obstacles are put in their way. They are usually asked, for example, to provide an address. This is difficult for anyone sleeping on the streets.

Numbers of homeless people in London by RHA

Districts	Temporary accomm.	Squatters	Hostels	Sleeping out	Travellers	TOTAL	%age pop.
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City & Hackney	3,506	5,600	0	92	34	9,232	4.7
Tower Hamlets	1,044	918	417	19	48	2,446	1.5
Hampstead	2,146	582	40	132	23	2,923	2.6
Haringey	9,492	508	0	0	204	10,204	5.3
Enfield	2,618	22	0	0	72	2,713	1.0
Waltham Forest	3,326	316	0	0	29	3,672	1.7
Newham	5,520	272	0	0	38	5,830	2.8
Redbridge	1,246	31	0	0	41	1,318	0.6
Barking, H & B	1,490	13	0	0	113	1,617	0.4
Subtotal	**36,077**	**9,133**	**1,128**	**597**	**617**	**47,552**	**2.0**
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Riverside	4,897	464	447	169	84	6,061	2.2
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Subtotal	**31,774**	**1,515**	**1,102**	**378**	**499**	**35,268**	**1.8**
South East Thames Region							
W Lambeth	3,066	2,454	195	174	24	5,913	3.8
Camberwell	2,782	3,782	425	0	124	7,113	3.4
Lambeth & NS	2,686	2,166	424	22	133	5,431	1.7
Greenwich	2,753	134	12	0	163	3,062	1.4
Bexley	240	53	0	0	38	332	0.2
Bromley	1.109	22	0	5	120	1,256	0.4
Subtotal	**12,636**	**8,612**	**1,056**	**201**	**602**	**23,107**	**1.6**
South West Thames Region							
Wandsworth	1,298	153	0	2	16	1,469	0.8
Croydon	4,781	4	0	36	41	4,862	1.5
Richmond T & R	1,210	65	0	58	42	1,375	0.6
Merton & S	1,330	0	9	0	96	1,435	0.4
Kingston & E	1,083	15	0	0	73	1,171	0.6
Subtotal	**9,701**	**238**	**9**	**96**	**267**	**10,311**	**0.8**
TOTAL	**90,188**	**19,498**	**3,295**	**1,272**	**1,985**	**116,238**	**1.7**

Sources: **1. Temporary accommodation:** London Health Authorities: Bed and Breakfast information exchange, March 1991. Out of London: Department of the Environment, 2nd quarter,1991. **2. Squatters:** Department of the Environment, HIP submissions, 1991. **3. Hostels:** London Hostels Directory, Resource Information Service,1991. **4. Sleeping out:** OPCS, Supplementary monitor on people sleeping rough, 1991. **5. Travellers:** Department of the Environment, count of gypsy caravans, July 1991.
For a full account of the compilation of these figures see the Access to Health booklet, *How to Count your Homeless Population.*

From *Primary Health Care and Homeless People: Responding to the Tomlinson Enquiry.* Access to Health 1993.

Its guide for purchasers, 'Purchasing and Poverty', offers clear statements and tenets which can be adopted by purchasers, and stresses that by addressing the needs of the most disadvantaged, contracts will address the needs of all local people.

Access to Health is currently monitoring the effect of these contracts on service delivery.

MORE POTENTIAL IN THE INTERNAL MARKET

Although in some areas – particularly those supported by Access to Health – the opportunities presented by the new NHS have been exploited in an attempt to improve the health of homeless people, there are still many areas where they have fallen off the agenda.

In some cases the plight of homeless people has taken a backward step because health authorities attempting to keep control of the cost of extra-contractual referrals may deny temporary residents the health care they need locally. But even where health authorities have begun to develop service specifications which take account of the problems of homeless people, this can only ever be the first stage and a close watch needs to be made on the accessibility and responsiveness of the services which develop from these.

The enormity of the problem must not prove paralysing. The health service must work with a range of agencies and professionals on a number of fronts to ensure a better deal for homeless people.

STEPS FOR ACTION

One of the potentially inhibiting facts for health care workers who want to improve the health of homeless people is that reducing homelessness is not within the limits of the health authority activity.

Yet there are roles for health workers beyond the provision of services. For example, those working in the NHS and in close contact with homeless people can, and do, lobby and campaign with and on behalf of homeless families as a complementary part of the job.

Others in the health service, particularly those with responsibility for the health of local populations, can press for better health and health care for homeless people by demonstrating the ill-effects of homelessness on health. Directors of public health, for example, can use the annual public health report to highlight the effects of homelessness on the local population and to make recommendations to guide commissioners of services.

Goals for services and management performance should be set to stimulate activities to improve homeless people's chances

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Number of households/people in temporary accommodation in England 1981-1991

	Total households	Number of people	Annual increase in number of people	Percentage annual increase
1981	4,840	11,616		
1982	9,340	22,416	10,800	93%
1983	9,840	23,616	1,200	5%
1984	12,300	29,520	5,904	25%
1985	15,920	38,208	8,688	29%
1986	20,790	49,896	11,688	31%
1987	24,760	59,424	9,528	19%
1988	30,100	72,240	12,816	22%
1989	37,900	90,960	18,720	26%
1990	45,270	108,648	17,688	19%
1991	59,930	143,832	35,184	32%

Source: DoE

In 1991, more than 12 times as many households in England were in temporary accommodation as in 1981.

Between the end of 1990 and the end of 1991 statutory homelessness increased by nearly a third.

From *King's Fund Annual Report 1992.*

Some GP surgeries also have highly restricted opening hours, unwelcoming reception areas, a lack of interpreting services, inaccessible locations and little information available about them. Such surgeries are more common in poor inner city neighbourhoods.

Two serious financial disincentives also exist which deter GPs from wishing to register homeless people as permanent patients. First, the fees which GPs receive for temporary registration, emergency treatment or immediate necessary treatment, are significantly greater than for permanent registration. This may result in a homeless person being registered for immediate necessary treatment only, which guarantees only 14 days of continuing care.

Secondly, since 1990 GPs have been paid for cervical cytology and immunisation on a target basis: they only get paid if they immunise/screen a target percentage of people on their lists. There is a 90 per cent target for immunising two to five-year-olds (or a lower fee for 70 per cent target) who are on their permanent list. The target for cervical screening is 80 per cent (50 per cent for a lower fee). There is no payment if the target is not reached. GPs are therefore reluctant to register permanently patients who they think might not turn up for screening or immunisation.

EXAMPLES OF GOOD PRACTICE WHICH HAS OVERCOME SOME OF THESE BARRIERS

When financial rules and regulations block fair access to health care, a considerable amount of flexibility is needed to find ways round the system. City and East London Family Health Services Authority has adopted such an approach – sometimes following the rules, sometimes bending them, and sometimes operating in the loopholes between them. For example:

- Homeless families are encouraged to register permanently with GPs, irrespective of the length of stay at an address. In this way families have a better chance of continuity of care.
- Not all GPs and homeless people want permanent registration, so the FHSA is exploring the idea of tracer cards which could pass easily and quickly, via the FHSA, from one GP to the next. These cards, which would be tagged in some way for easy identification and easy access, would be used in the place of the patients' full notes. Their full notes could be retained in their home borough (that is, the borough which originally accepted them as homeless), since many homeless people wish to remain registered in their 'home' area.
- Homeless families who are permanently registered may be removed from the cohort of patients counted for target payments if this is requested by a GP. In this way, registering such patients does not prevent a GP from meeting his or her targets. (The strategy is not automatic, however, and GPs often choose to leave some families in the cohort if they have previously attended for immunisation.) This approach – of removing families from the cohort counted for target payments – could mean that homeless families are even less likely to be screened or immunised since there is no financial incentive to do so. By itself, therefore, this is not an appropriate strategy for improving access to health care. However, City and East London FHSA has established a programme of screening and prevention which works specifically for homeless families.
- Item of service payments (where GPs receive a fee for a service) largely went out with the new GP contract. However, FHSAs can make item of service payments if the director of public health identifies a group in the population as being 'at risk'. City and East London FHSA has encouraged DPHs in their area to identify homeless families as 'at risk'. GPs can then receive item of service payments for immunisation and screening of temporary residents and people who are permanently registered but removed from the cohort.
- Some FHSAs encourage GPs to register homeless people who cannot provide an address, by saying that they will accept the address of the surgery, FHSA or day centre for administrative purposes.

Bending the rules to create financial incentives for GPs to work with homeless people is a positive step towards providing good primary care services for this vulnerable population.

None of these devices, however, overcomes the problem that some homeless people do not see it as necessary or worthwhile to register with a GP. This important question needs to be addressed. While ensuring that homeless people have access to GPs is of crucial importance, it is not the sole criterion when planning services for homeless people.

PLANNING SERVICES FOR HOMELESS PEOPLE

In planning services for homeless people, the NHS can learn a great deal from the voluntary sector – a powerful source of innovation and inspiration. In many areas, it has provided flexible, appropriate and accessible services. Examples include:

- The Thomas Coram Homeless Children's Project (partly funded by the King's Fund), which recognises that living in a bed and breakfast hotel is particularly difficult for young teenage girls at school, especially when they are not English speaking. The project offers opportunities for activities outside school, providing health information, space for homework classes, and organising physical activities like swimming and outdoor games.
- The London Connection (also funded by the King's Fund), which provides affordable nourishing food, showers and laundry facilities, as well as health advice, support and counselling for young people who are based in central London.
- The Piccadilly Advice Centre, which provides a drop-in advice, information and referral service, particularly for people who are young, homeless or new to London. They have used a grant from the King's Fund to help build better links with mental health statutory services, to find out more about the services on offer and to share information about their work with health and social care providers.

Health authorities should attempt to build on the principles and models developed within the voluntary sector.

INTRODUCTION OF THE INTERNAL MARKET AND THE PURCHASER/PROVIDER SPLIT INTO THE NHS IN 1991

The advent of the 'new' NHS in 1991, as a result of the NHS and Community Care Act 1990, offered a potentially dynamic structure for improving services.

The radical changes injected many with a new enthusiasm for planning and providing health care. There was the potential for using contracts and service specifications to design better services. There was the chance to re-interpret funding guidelines to take account of the population's health needs. Some saw the possibility that regions might begin to take on a new role as strategic development agencies.

In order to encourage a strategic approach, the King's Fund and the four Thames regional health authorities established a large-scale project, Access to Health, to influence service developments for homeless people on a number of fronts.

THE WORK OF ACCESS TO HEALTH

Access to Health has employed six members of staff, both full-timers and part-timers, operating from a central London location, and managed by a small steering committee, made up of personnel from the regions, local authorities, purchasing authorities, the voluntary sector and FHSAs.

It was set up in 1991 and was originally due to run only for 18 months, but has had its life extended until the end of 1993.

Using its position as a pan-London project, it has been able to take a regional, strategic view and establish clear guidelines and policies, for example, in including weighting for homelessness in funding allocations for districts.

Earlier work carried out by the King's Fund Institute discovered in 1991 that unplanned admission rates to hospital were between two and three times greater among homeless people than the rest of the resident population[16]. Access to Health has drawn on this work to devise a weighting formula for the homeless population within the four Thames regions. The formula suggests that homeless people (who make up 1 per cent of the population) should account for 2.4 per cent of the overall funding. This is now happening in this form at North East Thames for 1993/94.

The rest of its work falls into two key areas:

Sharing information

To increase the understanding of and the response to the needs of homeless people, Access to Health has collated information about different models of health care for homeless people from within and outside London. It has produced a series of 14 booklets which describe models, discuss advantages and disadvantages, outline key success criteria and provide contacts.

It has also produced an information leaflet for health authorities called 'How to Count Your Homeless Population', which provides advice on how to count the numbers of homeless people living in temporary accommodation, squatting, living in hostels, sleeping out, and those who are travellers.

It has organised conferences and seminars for representatives from the voluntary sector and local authorities.

Supporting developments

By providing advice and practical help and encouraging activity in areas where the need for change is clearly demonstrated, Access to Health has been able to help health authorities shape services on the ground. For example, under a North East Thames Regional Health Authority initiative, a two-year post based at Camden and Islington Community NHS Trust has been set up to provide training for health service staff working with homeless people and to develop a training pack and video to be used throughout the region.

Access to Health works closely with health authorities on the development of service specifications and contracts which take account of the needs of homeless people. Contracts and service specifications are a good vehicle for getting a better health service deal for homeless people because they can incorporate and build on good practice, develop strategy and introduce innovations.

It helps to draft and produce guidelines for specifications, and works with authorities and providers to ensure that quality specifications take account of the needs of homeless people.

It has had some success in influencing the wording of contracts in London districts. Six out of seven of the inner London health authorities referred to homeless people in their service specifications in 1992/93.

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Wandsworth	1,298	153	0	2	16	1,469	0.8
Croydon	4,781	4	0	36	41	4,862	1.5
Richmond T & R	1,210	65	0	58	42	1,375	0.6
Merton & S	1,330	0	9	0	96	1,435	0.4
Kingston & E	1,083	15	0	0	73	1,171	0.6
Subtotal	**9,701**	**238**	**9**	**96**	**267**	**10,311**	**0.8**
TOTAL	**90,188**	**19,498**	**3,295**	**1,272**	**1,985**	**116,238**	**1.7**

Sources: **1. Temporary accommodation:** London Health Authorities: Bed and Breakfast information exchange, March 1991. Out of London: Department of the Environment, 2nd quarter,1991. **2. Squatters:** Department of the Environment, HIP submissions, 1991. **3. Hostels:** London Hostels Directory, Resource Information Service,1991. **4. Sleeping out:** OPCS, Supplementary monitor on people sleeping rough, 1991. **5. Travellers:** Department of the Environment, count of gypsy caravans, July 1991.
For a full account of the compilation of these figures see the Access to Health booklet, *How to Count your Homeless Population.*

From *Primary Health Care and Homeless People: Responding to the Tomlinson Enquiry.* Access to Health 1993.

Its guide for purchasers, 'Purchasing and Poverty', offers clear statements and tenets which can be adopted by purchasers, and stresses that by addressing the needs of the most disadvantaged, contracts will address the needs of all local people.

Access to Health is currently monitoring the effect of these contracts on service delivery.

MORE POTENTIAL IN THE INTERNAL MARKET

Although in some areas – particularly those supported by Access to Health – the opportunities presented by the new NHS have been exploited in an attempt to improve the health of homeless people, there are still many areas where they have fallen off the agenda.

In some cases the plight of homeless people has taken a backward step because health authorities attempting to keep control of the cost of extra-contractual referrals may deny temporary residents the health care they need locally. But even where health authorities have begun to develop service specifications which take account of the problems of homeless people, this can only ever be the first stage and a close watch needs to be made on the accessibility and responsiveness of the services which develop from these.

The enormity of the problem must not prove paralysing. The health service must work with a range of agencies and professionals on a number of fronts to ensure a better deal for homeless people.

STEPS FOR ACTION

One of the potentially inhibiting facts for health care workers who want to improve the health of homeless people is that reducing homelessness is not within the limits of the health authority activity.

Yet there are roles for health workers beyond the provision of services. For example, those working in the NHS and in close contact with homeless people can, and do, lobby and campaign with and on behalf of homeless families as a complementary part of the job.

Others in the health service, particularly those with responsibility for the health of local populations, can press for better health and health care for homeless people by demonstrating the ill-effects of homelessness on health. Directors of public health, for example, can use the annual public health report to highlight the effects of homelessness on the local population and to make recommendations to guide commissioners of services.

Goals for services and management performance should be set to stimulate activities to improve homeless people's chances of better access to services. This could include the following, all of which should be done with a specified date in mind:

Improving co-ordination

- DHAs and FHSAs to establish collaborative mechanisms to examine access to both primary and secondary health care for homeless people, identify the barriers to access and develop a realistic plan to remove them.
- DHAs and FHSAs to establish structures to collaborate with all relevant local authorities and voluntary organisations to plan and deliver a co-ordinated pattern of services for homeless people.
- Local authorities, in collaboration with health authorities, to develop joint codes of practice on standards and conditions for temporary accommodation which take account of the health of homeless people.
- Local authorities, HAs and FHSAs to implement a system of notification of homeless families placed by local authority homeless persons' units into temporary accommodation within the HA/FHSA area, to enable health professionals to make contact as soon as possible.

Removing barriers to services

FHSAs and DHAs to develop and implement a range of measures in order to reduce the difficulties homeless people experience in gaining access to health care. These will be integrated into mainstream provision through the contracting process.

- Representation to be made to the Department of Health to ask them to assess the barriers to providing care for homeless people – for example, when registration rules and GP payment systems make it difficult to provide primary care to people living in temporary accommodation, or where homeless people fall through the internal market net and no-one takes responsibility for funding their health care.

Information and monitoring

- Information systems and local research programmes to be developed to provide more reliable information and analysis on levels, distribution and causes of homelessness.
- DHAs to develop tools to measure the need for health services for homeless people and to identify ways of providing the most appropriate services to meet those needs.

There are also possibilities for developing a whole range of targets for specific groups within the homeless population, as follows:

Health of pregnant women, infants and children

- To decrease stillbirths and deaths in infancy among children of women living in bed and breakfast hotels by a specified amount.
- To improve the continuity of care between hospital and domestic settings for women living in temporary accommodation.
- To ensure that all women with newborn babies living in temporary accommodation are seen by a health visitor in their domestic setting in the first week of returning from hospital.
- To ensure that the level of child immunisation achieved for children living in temporary accommodation reaches the level achieved by children in the general population.

Prevention of accidents

- To ensure that the level of accidents in the home (whether in bed and breakfast hotels or hostels for single people) is reduced to the level in the general population.
- To work with environmental health departments to ensure that effective safety precautions are taken in bed and breakfast hotels and hostels for single people.

Mental health

- To ensure the effective monitoring of discharge policies.
- To ensure continuity of care for people discharged from long stay and acute psychiatric units to temporary accommodation.

CONCLUSION

The main message is that in order to improve access to health services for homeless people, improvements have to be made across the board: the problems faced by homeless people (and other disadvantaged groups) should be at the forefront of planners' minds when all services are commissioned. Solutions, otherwise, are inevitably *ad hoc*, small-scale, vulnerable and separate.

REFERENCES

1. Victor, C. Health status of the temporary homeless population and residents of North West Thames Region. BMJ 15 August, 1992.
2. Scheuer, MA *et al.* Homelessness and Utilisation of Acute Hospital Services in London, Occasional Paper 4. King's Fund Institute, 1991, p8.
3. Dobson, J. A Rotten Place to End Your Days. Health Service Journal,12 December, 1991 p16
4. Homeless Families, case study no 13. Riverside Public Health Department, November 1991.
5. Howarth, V. A survey of families in bed and breakfast hotels: report to the Governors of the Thomas Coram Foundation for Children. June 1987.
6. Health Visitors Association and General Medical Services Committee of the British Medical Association (HVA & BMA), Homeless Families and their Health. BMA 1988.
7. Conway, J (ed). Prescription for Poor Health: The crisis for homeless families. SHAC, Shelter, London Food Commission, Maternity Alliance, London 1988.
8. HVA/BMA *ibid.*
9. Greve, J. Homelessness in Britain. Joseph Rowntree Foundation 1991.
10. See, for example, Government Statistics on Housing and Homelessness, Department of Environment, Scottish Office, Welsh Office. Audit Commission, 1989.
11. Greve, J . *ibid.*
12. Shiner P. and Leddington S. 'Sometimes it makes you frightened to go to hospital... they treat you like dirt'. Health Service Journal, 7 November 1991.
13. Victor C. *ibid.*
14. Stern and Stilwell. 'From the margins to the mainstream'. West Lambeth Health Authority 1989.
15. Scheuer, MA. *et al ibid.*

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