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Rapid review of inequalities in health and access to healthcare for people experiencing homelessness in the UK

December 2024

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Background

People experiencing homelessness (PEH) face significant inequalities in health outcomes and in access to healthcare services[1,2]. Co-occurring needs and health conditions are common amongst this group and often overlap with additional risk factors which act to compound disadvantage and inequalities in outcomes. These include:

- adverse childhood experiences, including childhood homelessness, living in care and parental substance misuse, which can initiate social exclusion and perpetuate generational cycles of disadvantage[3,4];
- additional experiences of social exclusion and disadvantage, including imprisonment, substance misuse, mental ill-health, 'street culture' activities such as sex work[3,5], and domestic abuse (which particularly affects women)[6];
- poverty, which often precedes and prolongs homelessness[7]; and
- the co-occurring "tri-morbidity" of substance misuse, mental health and physical health problems[5].

Many of these needs and disadvantages have a bi-directional relationship with homelessness, meaning that these issues can increase the risk of becoming or remaining homeless, whilst homelessness can increase the risk of, or exacerbate, these issues[1,8]. These bi-directional relationships can act to strengthen inequalities in health and social outcomes for people who experience multiple and compounding needs and disadvantage. As one of society's most vulnerable and socially excluded groups[5], significant attention is needed to improve health outcomes and reduce health inequalities amongst PEH.

The Office for Health and Improvement and Disparities (OHID) provides guidance to support professionals who work with PEH, including suggested actions to prevent ill ill-health and promoting wellbeing in everyday practice[9,10]. An evidence review exploring the needs of PEH, focusing particularly on those who rough sleep and beg, is also available from Public Health England (now OHID)[11]. However, these resources are several years out-of-date and have been followed by an increasing number of studies published in recent years that explore the needs and experiences of PEH. These studies are particularly valuable in beginning to address the evidence gap around the views and perceptions of PEH, which has previously been under-researched.

Aim and scope

This rapid literature review provides an up-to-date overview of quantitative studies estimating the extent of health and healthcare inequalities for PEH, and qualitative studies exploring the perceptions of PEH and the professionals who support them, around barriers and facilitators to accessing healthcare in the UK. Reviews and primary research studies are included, although evaluations of specific services and interventions are out of scope.

Access to other support services, such as social care and housing support, is out of scope, due to the wide variety and remit of such services. However, many of the barriers and facilitators for accessing these support services overlap with those reported for healthcare services[12]. Moreover, the common experience of having multiple needs and disadvantages, which require both health and social support, means that poor access to one service may result in, or compound, poor access to another for PEH – i.e., integrated delivery of holistic services is key for this vulnerable population (as discussed below).

Scale of homelessness

Homelessness is not one single situation, nor are all types of homelessness alike. Under the umbrella of homelessness are those who are:

- ‘roofless’ – including those ‘sleeping rough’ in public areas and parks or woodlands;
- ‘houseless’ – including those living in hostels or temporary accommodation; and
- in ‘insecure’ accommodation – including those who are sofa-surfing[13].

Definitions of homelessness vary, however, and official statistics quantifying the extent of homelessness are often limited to records of those who seek government support and, via rough sleeper counts, those in the most extreme and visible need.

In England in 2023/24, nearly 65,700 households were accepted by local authorities (LA) as being unintentionally homeless and eligible for support to secure stable housing, whilst an additional 24,300 were recorded as homeless but ineligible for support[14]. The number of “hidden homeless” households, including those sleeping rough, sofa-surfing, living in hostels or in unsuitable and unconventional accommodation, was estimated at around 242,000 in 2022[15], including over 4,000 rough sleepers (2023 estimate)[16]. Homelessness has been rising for over a decade and is projected to continue increasing without national policy change[15].

Although homelessness encompasses a wide variety of situations, most research exploring the needs, outcomes and experiences of PEH focuses on those who live in hostels or those who access homelessness health services or day centres. This briefing will thus focus on this population, which includes those who are frequently or chronically homeless and those who rough sleep.

Health inequalities

Quantifying the scale of health need and outcomes amongst PEH is a challenge, due to low uptake of health services amongst this population and, where people do engage, housing status often not being recorded by mainstream health services[2]. Nonetheless, reviews find that health outcomes amongst PEH are significantly poorer than those of the general population worldwide, with increased rates of morbidity and premature mortality[1,2].

In the UK, analyses of the records kept by specialist homeless health services and hostels similarly indicate substantial health inequalities amongst PEH[17-21]. However, the data bias towards those who have engaged with services may mean that these studies underestimate the true extent of need in this group.

Morbidity amongst PEH

Greater exposure to behavioural risk factors is likely to contribute significantly to increased morbidity and early mortality in PEH[1], including greater use of alcohol, illicit drugs and tobacco[18].

PEH have a higher prevalence of substance misuse and mental health disorders than the general population[1,2], with alcohol and drug dependence estimated to be the most prevalent mental disorders in this population[22]. Prevalence data from the UK is out-dated or limited by small sample sizes but does indicate a substantial burden of substance dependence in PEH, such as one small study estimating a 50% prevalence of alcohol dependence (confidence intervals: 41-59%) in PEH accommodated in hostels in southern England[23].

UK studies also find an increased prevalence of infectious diseases, particularly hepatitis C, amongst PEH compared to the general population[18], and a nearly three-times prevalence of chronic illnesses, including respiratory conditions, cardiovascular problems and diabetes[20].

Multi-morbidity is common amongst PEH and experienced at an earlier age, with studies finding that the number of co-occurring conditions and frailty levels in relatively young homeless adults are comparable to much older adults in the general population[18,21]. Physical health conditions commonly co-occur with mental health or substance misuse problems[19], or as a “tri-morbidity” of all three[5].

Mortality amongst PEH

Homeless populations experience premature mortality rates estimated to be more than double those of the general population[1,2]. In England and Wales, the average age of death of PEH is estimated at around 43-45 years[24], which is nearly half the average age of death amongst the general population[25].

Official estimates identify drug poisoning, suicide and alcohol-specific causes as the leading causes of death amongst PEH in England and Wales[24]. However, analyses of deaths reported by specialist homeless health services in England also highlight the substantial mortality burden of chronic conditions, finding that cardiovascular, cancer and respiratory diseases are the most common underlying causes of death, alongside external causes[17]. Importantly, a substantial proportion of these deaths are preventable: nearly a third of deaths reported by these specialist homeless health services are attributable to causes preventable with more timely healthcare[17].

Access to healthcare

Inequalities in healthcare access

Contributing to poor health outcomes are the atypical patterns with which PEH access primary, secondary and emergency healthcare. PEH are significantly less likely to be registered with a GP than the general population[26] and instead access emergency health services at 60-times the rate of the general population[18]. This delayed presentation to services, often at crisis point or with worsened health, is likely to contribute to late treatment and poor outcomes. Emergency re-admissions, following an initial healthcare episode, are also more frequent in PEH[27], suggesting a lack of sustained engagement with, or signposting to, health and other support services.

Qualitative research with PEH and the professionals who support them, including healthcare and hostel staff, provides insight into the range of barriers and facilitators that can limit or enable the accessibility and uptake of healthcare. These barriers and facilitators are explored below.

Barriers to healthcare access

Perceived barriers to accessing healthcare services can be broadly split into structural or material, interpersonal, individual, and prioritisation and control barriers. Many barriers of these types also limit access to other support services, such as social care and housing support.

Structural or material

Many barriers relate to administrative or organisational structures, which create health services that are inflexible to the needs and lifestyles of PEH[28]. These include rigid and short appointment times, intolerance to missed appointments, and long waiting times[28-34]. Continuity of care is affected by poor coordination and communication between services, particularly for those with multiple needs[28-30,35,36]. The co-occurring nature of multiple needs can itself be a barrier to accessing services, such as substance misuse often being an exclusion criterion for mental health services, and vice versa[28,30,34].

Lack of material resources further limits access to care, including money to travel to services, which can often be distant or located in multiple sites[30,33], and no home address or internet access, which can impede GP registration and communication[30,34,36].

Lack of resources, such as facilities to store medicines or to prepare for diagnostic procedures, can also impede self-management of health conditions[30,34,35].

Interpersonal

Negative interactions with healthcare staff, such as feeling stigma, discrimination, and uncared for or belittled, can alienate and exclude PEH[29-34,36]. These experiences of poor staff attitudes may be perceived[36] – for example, due to poor self-esteem or embarrassment[30,32-34] – or actual, due to staff lacking knowledge of the difficult histories and lifestyles that are typical of PEH[30,34,36]. Regardless of root cause, these negative interactions can lead to a lack of trust in, and poor relationships with, healthcare staff[28,30,31,33,36] and ultimately result in poor engagement.

The perceived formality of healthcare settings and power of healthcare professionals can also create feelings of anxiety, meaning PEH may struggle to communicate their health needs or avoid these settings altogether[31,33,34].

Individual

Low health literacy can limit engagement with health services, including poor awareness of symptoms and of available and appropriate services[28,33-35]. Lacking knowledge and skills to navigate services can further affect access[28,30].

Physical and mental abilities may also reduce service uptake. This includes pain or disabilities preventing walking to services[30,33], poor memory or intoxication resulting in missed appointments[33,34], and poorly articulated health needs resulting in missed diagnoses[29,31,34].

Prioritisation and control

Healthcare is often described as not being a priority for PEH[28], particularly for those who sleep rough[30,34,36]. Basic needs, such as food and shelter, come ahead of accessing healthcare[30-36], as does attending to addictions and other mental health issues[32,33,36].

Although PEH show awareness of the negative impacts of unhealthy practices, they also describe a perceived lack of control over their health[32,36]. This can lead to self-medication with alcohol and illicit drugs[32] and feelings of hopelessness and fatalism[33]. PEH may also not perceive their health needs[28] or may avoid or deny their existence[28,33].

Facilitators to healthcare access

There are a range of approaches that are perceived by PEH and those who support them to be possible facilitators to healthcare access for PEH, many of which address the barriers described above. Many of these may also act as facilitators for accessing other support services. These include information and education for professionals, peer education and advocacy, and holistic, coordinated and tailored service delivery.

Information and education for professionals

Training and education for professionals who support PEH, including healthcare and community-setting professionals, is perceived as important to improve the knowledge and attitudes of these professionals around the needs and experiences of PEH[5,28]. This includes knowledge of:

- How to navigate healthcare pathways and services, to enable signposting, referrals and smooth transitions between relevant and appropriate services[28,29,37].
- The multiple and compounding needs that many PEH face, which may act as additional barriers to accessing healthcare and other services[28-30,38]. Several studies suggest that trauma-informed and psychologically-informed approaches may enable professionals to better understand and support PEH[29,31,38].

- The need to give advice that is realistic to the lifestyles of PEH and to use simple and accessible language[28,34].

Peer education and advocacy

Training and utilising peers as educators, advocates and chaperones can support PEH to engage with services, including reducing feelings of anxiety and intimidation and helping with communication during consultations[5,28,34]. Professional advocates, such as support workers, are also seen as helpful[34,38]. However, some studies find that support workers can feel that they are not listened to or that their input is not respected by healthcare professionals, despite their familiarity with the needs of the PEH that they support[29,38].

Providing training for peer educators can also support information dissemination and awareness-raising about health behaviours and available services within networks of PEH[28].

Holistic, coordinated and tailored service delivery

Well-coordinated services are seen as a facilitator for PEH to access healthcare, including good relationships between services and professionals within the health, social care and wider community support systems[28,29,37,38]. As part of this coordination is a need for holistic services that recognise and are tailored to meet the multiple needs of PEH[5,28,30,38]. Flexible 'one-stop-shops', where PEH can access practical support to address their basic needs, alongside health and social support, are valued by PEH[5,28,38] and enable opportunistic access to services, rather than PEH being required to seek out services[31].

There are various approaches to tailor service delivery to the needs and lifestyles of PEH. These address many of the barriers described above and can support greater uptake of services, including screening and vaccinations[28]. Flexibility and accessible location are perceived as key facilitators in these approaches, many of which overlap in design. Examples include:

- Outreach into community settings, such as homeless hostels and day centres. GP and nurse-led outreach clinics, with drop-in appointments, can provide a more relaxed, informal setting in which PEH may feel more comfortable, whilst allowing PEH to bypass some of the administrative barriers that may be experienced in mainstream settings[5,28,29,31,34,37,38].

- Specialist homelessness healthcare centres, which may have their own premises with additional services provided or be based in an existing community setting (e.g., permanent clinics in homeless hostels and day centres)[28,30].

- Mobile services, such as GP-led buses, can support access by taking healthcare services directly to PEH, including those sleeping rough[28,34].

- Specialist roles, such as navigators and public health or district nurses, can provide continuity and support to PEH during service transitions and following hospital discharge[28,38].

Underpinning these examples of tailored service delivery is a need for trusting and empathetic relationships between PEH and healthcare providers[5,28,30,31,37] and autonomy in health-related decision-making[5,28,31]. Continuity, familiarity and availability of services is perceived as key to establishing this trust in professionals and services[34].

Conclusion

People experiencing homelessness are a vulnerable and socially excluded population who often face multiple needs and disadvantages, which require both healthcare and social support. Compounding these co-occurring needs and disadvantages are barriers to accessing healthcare, which can exacerbate and lead to substantial inequalities in health outcomes. These barriers include inflexible organisational and administrative structures, lack of trusting relationships with healthcare professionals, and low health literacy. Many of these barriers to healthcare also represent barriers to other support services, such as social care and housing support. Facilitators to improve healthcare access include services that are holistic, coordinated and tailored to the needs of the homeless population, education for professionals, and utilising peers, including peer-education and advocacy.

Further resources

- Guidance around providing integrated health and social care services for PEH is available from the National Institute of Health and Care Excellence (NICE)[39].
- Further evidence and recent data on admissions to hospital for PEH is available at a regional and Integrated Care Board (ICB) level from OHID[40].

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