# Bridging the gap between health care and no care: the homelessness crisis

Chantal Simon and Maggie Kirk

It is difficult to estimate how many people are homeless in the UK but, just taking rough sleepers on a single night in autumn 2023, it was estimated there were 3898 rough sleepers in England; a 120% increase since 2010.[1]

People experiencing homelessness suffer from worse physical and mental health than the general population: 63% report long-term illness, disability, or infirmity; 82% have a mental health diagnosis; they have reduced life expectancy; and, a third die from medically treatable conditions.[2]

Many are homeless because of adverse life events. This can lead to a lack of confidence in services, and 45% say that they self-medicate with drugs or alcohol to help them cope with their problems.[2] Poor mental health and chaotic lifestyles may lead to self-neglect and treatable medical conditions are frequently left untreated, often developing into emergencies.[2]

As a result, services are firefighting when patients experiencing homelessness present in crisis. Lack of accessible primary care leads to over-reliance on emergency departments and secondary care. For example, in the past year, 48% of people experiencing homelessness attended accident and emergency (three times more than the general population), and 38% had at least one hospital admission, with 24% discharged back to the streets.[2]

*"Patients experiencing homelessness report negative experiences of accessing mainstream health services. Accounts of being denied registration at general practices and being discharged from hospital onto the streets with no access or referral to primary care providers are common."*

## Why is it difficult for people experiencing homelessness to access primary care services?

Patients experiencing homelessness report negative experiences of accessing mainstream health services.[3] Accounts of being denied registration at general practices and being discharged from hospital onto the streets with no access or referral to primary care providers are common.[3]

Many factors limit access to primary care. Physical ill health, frequent changes of address, lack of transport, and social and digital exclusion make it challenging for patients experiencing homelessness to even register with a GP. Once registered, chaotic lifestyles often lead to missed appointments, and lack of continuity denies patients experiencing homelessness the chance to build constructive relationships to address problems. Low income and lack of storage make adequate nutrition difficult and management of regular medication almost impossible.

However, there is also an attitudinal barrier; failure to keep appointments, lack of adherence to management plans, and antisocial behaviour may alienate health and social care professionals. The NHS is struggling to manage burgeoning demand in the wake of the COVID-19 pandemic, compounded by increasing life expectancy. Patients' expectations are unmet and the workforce is demoralised.[4] When faced with a patient experiencing homelessness it is common to hear frontline NHS staff say: *'We can't deal with this'*.

The NHS is not set up for the needs of people experiencing homelessness. At best, mainstream care patches up problems; at worst, people go unseen, unheard, undiagnosed, and untreated. This results in frustration for all — clinicians, patients, and allied services.

## What does 'no care' look like?

'No care' becomes more likely as accessing services becomes more challenging: a person with painful festering leg ulcers, sleeping rough, deducted from the GP list due to serial non-attendance. Unwashed bandages and toilet roll to dress wounds is not aiding recovery. Intravenous drug use manages physical and emotional pain but sepsis and amputation are real risks.

This case scenario may seem impossible in 21st century Britain but is representative of stories commonly heard. Specialist homeless care services are set up to manage scenarios like this, but the intensive input needed is beyond the means of most mainstream general practices.[5]

But, why should patients experiencing homelessness have special care? Because the alternative is often no care except in an emergency. Bridging the gap between health care and no care is essential to reduce health inequalities and create a starting point for recovery; it is hard to recover without health.

Moreover, it makes financial sense for the NHS. Around 80% of the cost of caring for people experiencing homelessness relates to unscheduled emergency care and hospital admissions.[6] Providing effective care in the community is estimated to save 24% of total healthcare costs associated with patients experiencing homelessness.[6] Furthermore, care in the community may be the start of the patient's engagement: a therapeutic relationship, discovering self-esteem, and hope of recovery.

## Creative solutions

Out of these frustrations, creative solutions have emerged. The Complete Care Community Programme recommends four T's for addressing health inequalities:

- **trust** in relationships between recipient and care provider, and between care provider and other agencies involved;
- **transparency** about how the service works and how care decisions are made;
- **training** to understand the needs of the population served; and
- **time** and resources to address the three points above at both individual and system levels.[7]

Bournemouth, Christchurch, and Poole conurbation has the third highest number of rough sleepers in the UK after London and Bristol.[1] Using the four T's principles and patient feedback, the HealthBus Trust has evolved as an independent, GP-led, accessible, outreach, specialist homeless service.[8] It provides compassionate, non-judgemental care with practitioners trained in specialist homeless care, who can provide continuity of therapeutic relationships. The service is mobile, taking care to patients and acting as a one-stop shop, connecting and supporting them to engage with multiple teams to enable their recovery. The HealthBus Trust has over 500 registered patients experiencing homelessness (50% of those known to be homeless in the conurbation) and delivered 3727 clinical interventions in 2023–2024, including GP, nurse, and mental health consultations.[8]

The restructuring of services required to integrate solutions proportionate to the needs of homeless populations demands creativity and a willingness to do things differently. The HealthBus Trust is a working solution to a complex problem, embodying the recommendations of the National Institute for Health and Care Excellence guidance for integrated health and social care for people experiencing homelessness,[9] the Public Health England guidance on inclusion health and homelessness,[10] and learning from the HEARTH study.[5]

## Social injustice

Core principles of the NHS Constitution apply throughout the UK and pledge a comprehensive health service available to all, based on clinical need. Marmot's proportional universalism supports the resourcing and delivery of universal services at scale and at an intensity proportionate to the degree of need.[11] Integrated care systems in England were set up with four core purposes, including tackling health inequality and improving health outcomes for all.[12] Yet, sadly, services for people experiencing homelessness are not universally available throughout the UK and often, like the HealthBus Trust, rely on charitable funding to provide the flexibility to adapt to patient needs with the level of service required.

Lack of adequate healthcare provision for patients experiencing homelessness is a social injustice. Delivering accessible and high-quality care for the homeless would be a step towards reducing health inequalities, while alleviating pressure on emergency services and simultaneously reducing healthcare costs. However, repeated political pledges to address health inequalities have not been backed by action. Perhaps embracing and including innovative solutions for homeless care in the NHS might be an all-round win for patients, health care, and the new UK Government.

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**Provenance**
Commissioned; not externally peer reviewed.

**Competing interests**
The authors have declared no competing interests.

**DOI: https://doi.org/10.3399/bjgp24X739941**

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