Developments in the provision of primary health care for homeless people

IN 1952, Aneurin Bevan suggested that 'no society can legitimately call itself civilised if a sick person is denied medical aid because of lack of means.'[1] Homelessness represents poverty in its most extreme form. No-one is immune. Accurate prevalence statistics are elusive, complicated by problems of definition and legislative loopholes. However, it has been shown that up to 4.3 % of all current head of households in England have experienced a period of homelessness in the past decade.[2]

The Royal College of General Practitioners has stated that all people must have equity of access to health care.[3] However, homeless people often experience difficulty in gaining access to quality primary health care.[4] Primary care registration rates vary between 24% and 92% for homeless people, the former described in a study of rough sleepers[5] and the latter in families in bed and breakfast accommodation.[6] Barriers to care are poorly researched; however, limited work from a GP perspective suggests that lack of training, concerns over time-costs, and negative attitudes towards homeless people are significant issues.[7] Homeless people themselves report perceived reluctance from the primary care team and personal competing priorities as barriers to registration and care.[8] Yet this is a population with very significant health needs. In 1992, Crisis reported that the average age of death of 86 identified rough sleepers in London was 47 years.[9] A follow-up study, using records from the London Coroner's Courts from 1 September 1995 to 31 August 1996, found that 74 deaths of rough sleepers had been recorded and that life expectancy was 42 years,[10] compared with the national average of 74 years for men and 79 years for women.

Twenty years ago, the Acheson Report on primary care in inner London noted that mainstream primary care provision in London at that time was not engaging with the health needs of homeless populations.[11] One of the Report's many recommendations was that alternative provision should be made for providing primary care to homeless people. As a result, a number of new primary care services were set up around the country, including specific salaried GP posts, house doctor schemes, and mobile GP surgeries, whose role was to provide primary health care to the local homeless population. In 1996, a report for the Department of Health (DoH) noted that there were 13 dedicated primary care homelessness centres in England.[12]

PMS pilot schemes have led to a dramatic increase in the number of dedicated primary care homelessness centres. In guidance from the DoH, prior to the call for applications for first-wave PMS schemes, homeless people were specifically mentioned as a target group for PMS projects.[13] There are currently 25 primary care centres around the country which are under PMS contracts and specialising (or with a special interest) in the health care of homeless people. There are also several other specialist homelessness centres around the country that have contractual arrangements other than PMS.

It is important that specialised homelessness centres working under a PMS contract are not seen as a panacea for homeless people. Their obvious strength is that they overcome the time-cost disincentive to GPs working with homeless people. PMS contracts have the potential to replace or complement the capitation system of payment which forms a significant proportion of GP independent contractor pay. The obvious limitations of specialised services are that they may effectively absolve local GPs from providing primary care services and at worst may serve to ghettoise homeless people, rather than encourage their integration back into mainstream primary care. Limited research in this area shows that homeless people value specialised services.[14] Anecdotally, however, such value can act as a barrier to homeless people moving into mainstream primary care practices once they have become re-housed. Although PMS contracts are subject to local and national evaluation, it is questionable whether such evaluation will be sensitive or specific enough to address these issues.

Segregation of homeless people through PMS, however well meaning, is unlikely to resolve the health inequalities of homelessness. A better model might be inclusive service provision that combines specialised and mainstream primary care services. This would offer homeless people — for example, rough sleepers — the opportunity of registering with a specialised homeless practice when they are in crisis. Once their urgent needs have been met by the specialist skills available in such services, they could then be helped to permanently register within mainstream general practice. This model creates a bridge between separation and integration, opening up access to mainstream care for the majority of homeless people and also providing immediate transitional primary health care and social care services through interested GPs.

Primary care trusts, with their dual remit to work more closely with social services departments (supported by the potential provision of unified budgets for health and social care) and to commission primary health care for large populations, could be pivotal in organising and supporting this service model. New services would need to be guided by the views of service users underpinned by training, for example, to dispel the persistent barrier-inducing myths of mobility and registration regulations; and rigorously evaluated, since there is a paucity of conflicting research into the appropriateness and feasibility of such models.[15,16] Central policy developments around extending the nurse role in primary care also have potential to significantly improve the health of homeless populations. Nurse practitioners working alongside general practitioners in their practices could play a central role in supporting mainstream primary care, ensuring smooth transition of homeless people from specialised primary care centre to mainstream general practice, making links to community resources, and enabling effective networking with housing and social care. Such progress

towards mainstream health provision for the majority of homeless people may well take us a step closer towards Bevan's civilised society.

HELEN LESTER

Member, RCGP Health Inequalities Standing Group, and general practitioner, Lee Bank Group Practice, Birmingham

NAT WRIGHT

General practioner, NFA Health Centre, Leeds

IONA HEATH

Chair, Health Inequalities Standing Group

On behalf of the RCGP Health Inequalities Standing Group

References

1. Bevan A. *In place of fear*. London: William Heinemann Ltd, 1952.
2. Burrows R, Pleace N, Quilgars D. *Homelessness and social policy*. London and New York: Routledge, 1997.
3. Royal College of General Practitioners. *Statement on homelessness and general practice.* London: RCGP, 1993.
4. Fisher K, Collins J. *Homelessness health care and welfare provision.* Routledge: London 1993.
5. Leddington S. Sometimes it makes you frightened to go to hospital ... they treat you like dirt. *Health Services Journal* 1989; **11:** 21-22.
6. Victor CR. Health and lifestyles of homeless people. *Health Educ J* 1993; **52:** 79-84.
7. Lester HE, Bradley CP. Barriers to primary health care for homeless people — the general practitioner perspective *Eur J Gen Pract* 2001; **7:** 6-12.
8. Shiner M. Adding insult to injury: homelessness and health service use. *Soc Health Ill* 1995; **17:** 525-549.
9. Keyes S, Kennedy M. *Sick to death of homelessness*. London: Crisis, 1992.
10. Crisis. *Still dying for a home.* London: Crisis, 1996.
11. London Health Planning Consortium, Primary Health Care Study Group. [The Acheson Report.] *Primary health care in inner London.* Department of Health: London 1981.
12. Hewett N. *Primary health care for homeless people: a report for the Department of Health.* Department of Health: London 1998.
13. Department of Health. *Personal medical services: pilots under the NHS (Primary Care) Act 1997. A comprehensive guide*. London: HMSO, 1997.
14. Hewett NC. How to provide for the primary health care needs of homeless people: what do homeless people in Leicester think? *Br J Gen Pract* 1999; **49(447):** 819.
15. Department of Health. *Review of primary care projects for homeless.* London: Department of Health, 1995.
16. Williams S, Allen I. *Health care for single homeless people*. London: Policy Studies Institute, 1989.

Address for correspondence

Dr Iona Heath, 45 Canonbury Park South, London N1 2JL.