Socially Marginalised Populations and Their Health: Busting Myths and Shifting the Paradigm

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The stubborn problems of homelessness and other forms of social and economic marginalisation seem insoluble. The individuals and families affected have poor outcomes in health and life expectancy despite heavy use of healthcare. People experiencing homelessness are also overrepresented in other government services such as Justice, Corrections and Child Protection and often languish for years on social housing wait lists.

From my unique perspective as a frontline clinician in an inner city hospital's Emergency Department (ED) for over 20 years and the Clinical Lead of our hospital's Homeless Team and homelessness advisor and advocate for over five years at State Government, Western Australia (WA) Health Department and community homelessness service levels, the solutions for these issues are, in reality, straightforward and solvable. In this article, four common myths are busted and a way forward proposed.

Myth 1: Health is largely determined by the healthcare system

The major determinants of health, both on an individual and country level, are firmly based in social factors and not the quality and accessibility of the healthcare system. This has been quantified in a 2016 data analysis study across the entire United States (US) which showed that only 20 per cent of health status was directly related to the healthcare system, quality and accessibility.[1] In countries with universal, free at point-of-care healthcare such as the United Kingdom (UK) and Australia, the impact of social factors on health status is potentially even greater than the 80 per cent computed in this US study.[2]

Myth 2: Improving the health of socially and economically marginalised populations is best achieved by improving access to healthcare services

To really fix a problem, you have to fix the real problem.

A person sleeping on the streets with unstable diabetes needs housing and supports to improve their health. This will not be achieved by a person presenting with more hospital admissions and being given more diabetic education or tweaking an insulin regime. A purely medical approach results in patients cycling in and out of hospital until the underlying cause (homelessness) is addressed.

The universal bedrocks of good physical and mental health are social, namely stable housing, sufficient income, supports available when needed, positive social contacts and meaningful activity. Within our unequal societies, there is continuum of 'social wellness' and the bottom rung is chronic rough sleeping which carries an average life expectancy of around 50 years even in countries with ready access to high quality healthcare such as Australia and the UK.[3,4,5]

Numerous studies from around the world show that rough sleepers are also typically heavy users of expensive crisis services such as ambulance transport and ED presentations, often resulting in hospital admissions that are, on average, longer and more frequent compared to the housed population.

With escalating pressure on hospitals and healthcare systems across Australia, the purely medical model of responding to homelessness needs to change. As we have highlighted elsewhere,[6] homelessness interventions do not form part of mainstream healthcare. However, they can easily be incorporated into patient care in hospitals by partnerships with community homelessness organisations to deliver social interventions.[7]

Once social stability is achieved, previously homeless patients can enter mainstream health services, transitioning from expensive crisis hospital healthcare to lower cost planned primary care in General Practitioner (GP) clinics, hospital outpatient clinics and elective procedures.

Myth 3: Homelessness, the most severe form of social marginalisation, is just too complex to ever fix

In reality, the fundamentals of how to resolve homelessness, both acute and chronic, are well understood, and have a good evidence base to support their effectiveness.

The basic elements are:

1. safe, stable, affordable, accessible long-term housing
2. supports to keep the person housed at the level, duration and type required
3. long-term primary healthcare, starting with GP care

Two local WA examples of successful programs based around these three key elements in highly complex homeless populations are described below.

The *50 Lives 50 Homes* program in Perth focused on city's most complex, chronic rough sleepers

(VI-SPDAT 10+) over 2015–2018. Using a Housing First approach with wrap-around after-hours support, a total of 237 individuals were housed in 186 long-term accommodations within the first four years. As at September 2019, 81 per cent had sustained their tenancies for at least one year, with large reductions in healthcare and justice costs seen after people were housed.[8]

The Mental Health Homeless Pathways (MHHP) program at a large mental health service in Perth is working with long-stay homeless (largely rough sleepers) mental health inpatients who cannot be safely discharged from hospital until they have suitable accommodation and supports in the community, mostly 24/7 supported mental health accommodation. They remain in hospital at a cost of $1,514/day/person for a psychiatric bed,[9] due to the dire shortage of this type of accommodation in the community. The work of the MHHP has been to maximise attainment of suitable placements for this cohort through intensive social casework. This not only markedly improves the life of these individuals but also frees up expensive acute mental health inpatient beds that are in high demand for acutely mentally unwell individuals.

The MHHP outcome data from the first 23 individuals assisted into long-term supported housing is astonishing.[10] This cohort's total mental health inpatient days in the one year prior to housing was 3,167 days (average 138 days per individual) which dropped dramatically down to 68 days (average three days per individual) in the year post-housing, reducing bed costs from $4.8 million to $103,000 (1/47th).[11]

These programs have the potential to house and support significantly more individuals and, using these proven strategies, could eradicate chronic homelessness in Perth. However, their impact has been stymied by chronic, severe shortages of the government funded basics: social housing, mental health supported housing and the government funded but NGO delivered community support services delivered.

In this way, governments are shooting themselves in the foot because by under spending on social basics like housing and support services, they end up overspending massively on more expensive healthcare. A one night-stay in a WA Tertiary hospital ($2,967 per night)[12] is the equivalent to about eight to nine weeks of private rental, and one night in a mental health bed ($1,514 per night)[13] is equivalent to about four to five weeks of private rental, based on an average rent of $320–$350 per week for a one-bedroom property in WA.

The same economic equation applies to our prisons, overflowing with inmates whose crimes are largely rooted in poverty and marginalisation. The cost of imprisonment is one tenth of the daily tertiary hospital bed cost at ~$300 per day,[14] but the total costs incurred match or exceed healthcare costs because of the duration of prison sentences. At a 2017 Shelter WA seminar on homelessness, a representative of the WA Corrections department stated their prisoners released outright into homelessness have an 80 per cent chance being back in prison within 12 months, creating a cycle of perpetual spending and prison overcrowding.

Myth 4: It's too expensive to fix social marginalisation and homelessness

We really need to bust this myth wide open because it has sent many governments, including in Australia, into ineffective and wasteful spending on a grand scale. As the examples described above demonstrate, there is already a stupendous amount of money being spent on the consequences of homelessness. It would make sound economic sense to re-purpose a proportion of this money to finance the eradication of homelessness and other forms of severe marginalisation and put robust early prevention programs in place.

This process can be seen in action in Hilary Cottam's work with complex dysfunctional families in the city Swindon in the UK in 2009.[15] One typical chaotic family described in Cottam's book, had 20 years of unbroken contact with government agencies, and at the time, had 73 different services run out of 20 government agencies working with this family of five at a cost of over £250,000 per year or £5 million over the 20 years. Through observing this directly, Cottam realised that the government services were delivered in agency 'silos' with no coordination, no overall plan or direction and no outcome focus. There was simply an endless treadmill of futile, expensive activity.

In 2009, the UK had estimated that there were 100,000 families with similar circumstances, each incurring £250,000 per year in government services; an estimated total of £25 billion per year, every year (AUD $46 billion per year).

Cottam's radical intervention program, *Life*, cost £19,000 per family and was based around reducing supports to only those the families chose as helpful, with a goal and plan to get there determined by the family. It was delivered over 18 months and resulted in this and other families no longer requiring special government services as they had joined mainstream life, often for the first time in generations.

We also have Australian evidence on how socially disadvantaged individuals can incur astonishing levels of institutional interventions and costs over a lifetime. This has been shown by the seminal work of New South Wales (NSW) criminology academic Eileen Baldry.[16] Her team developed costing methodology across multiple NSW government agencies including Police, Juvenile Justice, Corrective Services, Community and Disability services, Courts, Health and Housing. This allowed the calculation of the lifetime institutional costs of 11 complex individuals, ranging in age from 23 to 55 years old. These ranged from $900,000 to $5.5 million, the highest cost being associated with the youngest individual.[17]

Baldry reiterated Cottam's conclusions about the siloed nature of government service systems, the lack of comprehensive service supports and the failure to intervene early and effectively. This resulted in extraordinary levels

of subsequent service spending which continually failed to address the individual's core and basic issues. In the conclusion, she writes:

> *The lack of adequate services early in the lives of these individuals is associated with very costly criminal justice, health and homelessness interactions and interventions later in their lives. millions of dollars-worth of time and resources by Police, hospitals, courts, Juvenile Justice and Corrective Services continue to be spent on a relatively small number of individuals. Early and well-timed interventions to establish and maintain secure housing and associated support services will likely reduce if not obviate the need for the future years of criminal justice interventions.*[18]

The Way Forward

From my double perspective of working in the health system and with homelessness services, the futile, wasteful and ruinous government spending on 'essential services' such as Health, Police and Corrections contrasts starkly with the spending on our social safety net (Housing, Community, Child Protection and Family Services) which is ridiculously limited and unstable. This includes the government funding of non-government organisations (NGOs) who provide many of these frontline services. By inadequately responding to the relatively cheap social needs of our communities, the high costs of social marginalisation, both economic and human, are endlessly and needlessly perpetuated.

In Australia, there are glaring examples of this in the paucity of social and affordable housing resulting in the 2016 Census finding 116,427 individuals experiencing homelessness, including 8,200 rough sleepers, and the well-publicised chronic lack of refuge places to assist women and children escaping family and domestic violence such that many are unable to access help.

Repurposing of a fraction of the futile 'band aid spending' would allow social interventions to be funded to respond to the full need rather than a fraction of it and reduce pressure on many government services in both the short and long term.

What is needed is:

i. Whole of government commitments to reducing wasteful spending by 'spending right' and shifting money to where it has the most impact. It starts with the holders of the government 'purse strings' looking for value for money spent and evidence based spending with an eye to the wider implications of funding decisions, for example, positive/negative impacts on other services, and to future spending trajectories. We are all impacted by government spending decisions because, whether we personally need the social safety net or not, the costs of wasteful spending are, ultimately, borne by the taxpayer.

ii. A new relationship based on recognising the reciprocal need of government agencies involved in providing the social safety net and the NGOs funded to do much the frontline work. Properly resourced, these partners have the power to resolve many government spending problems but need bold targets and the means to achieve them, for example, eradicate rough sleeping, eliminate social housing wait lists, have enough family and domestic violence refuge places and supported mental health accommodation places to always rapidly meet need and have early diversion-to-intervention programs for chaotic individuals and families. Using outcome and future focused interventions would produce better outcomes for everyone, not the least of whom are our society's most disadvantaged and marginalised individuals.

There is no longer any excuse. The economic consequences of providing or not providing a robust social safety net are straightforward and have been backed by evidence for many years now. This paper busts some of the main myths around the health of our socially marginalised populations and ways to prevent their early deaths: it requires simple and less costly social interventions. In doing so, we can be both fiscally responsible and humanitarian.

Endnotes

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