UCL INSIGHTS: RESEARCH BRIEFING

Improving health outcomes for the most vulnerable in society

What is the problem?

It has been known for a long time that poverty is associated with poor health. This research has found that people at the very margins of society, such as those who are sleeping rough or selling sex, have very high risk of illness, injury and death, far greater than those for people living in areas of high social deprivation.

While health inequalities are commonly observed in the general population, people within the excluded group, including people with substance use disorders, prisoners, female sex workers and homeless people, have a significantly higher risk of illness and death. Evidence indicates that people excluded from mainstream society in high-income countries have a **tenfold increased risk of early death**.

Women in these groups are 12 times more likely to suffer illness or die that other women of the same age, while **men are 8 times more likely to die**. For comparison, the most marginalised men in society are at 5 times greater risk of illness and death than serving soldiers, with the risk increasing to 10 times more likely for women. It is therefore much more dangerous to be in one of these socially excluded groups than it is to be a soldier serving in the UK armed forces.

The causes of excess morbidity and mortality in these socially excluded groups are not that different from the causes of health inequalities more generally, but they are different in degree and in complexity, and have their roots in adverse childhood experiences and poverty.

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KEY MESSAGES

- People excluded from mainstream society in high-income countries have a **tenfold increased risk of early death**.
- **Women are particularly vulnerable** and at even greater risk than men
- The **needs of these groups can be better served by preventative social measures** such as reducing child poverty and providing safe housing
- **Evidence is limited for structural interventions** – such as providing access to housing, employment, and legal support

These highly marginalised groups often find it difficult to access GPs and preventative services such as screening. Long-term conditions such as diabetes and circulatory problems are often poorly managed. This means that people in these groups have high rates of hospital attendance and emergency treatment.

Numerous interventions to improve physical and mental health and treat substance use already exist. However, evidence is limited for structural interventions – such as providing access to housing, employment, and legal support that can prevent exclusion and promote recovery.

What can be done?

Consider the determinants of social exclusion. The scientific evidence focuses on interventions that improve the health and wellbeing of individuals. These approaches are unlikely to change social and economic factors such as the cost of housing and education that cause homelessness, sex work and other forms of social exclusion. Many people in excluded groups report histories of trauma and family problems, which are also strong determinants of social exclusion.

The most effective upstream prevention policy is likely to be in reducing material poverty and deprivation, especially among families with children who are at high risk of maltreatment.

Provide support which is 'personalised', that is open-ended, persistent, flexible and co-ordinated and ***deinstitutionalised***, giving people the option of staying in ordinary housing with the support that they need rather than being obliged to spend a period in hostels, refuges or other congregate settings if that is not their wish.

Focus on housing. Provision of suitable and stable housing in ordinary community settings should be an overriding policy objective in strategies tackling social exclusion. The 'Housing First' policy is effective and involves integrated physical, mental health and addictions support provided after prompt housing, rather than waiting for the person to engage with services prove themselves "housing ready".

Provide investment proportionate to the level of disadvantage. Excluded groups should be given a highly prioritised policy position, reflecting the intensity of their needs and exceptionally poor outcomes.

Provide care-co-ordination across health and care services. Evidence based Inclusion Health interventions should be integrated, multi-component, with case management and care coordination **including health and non-health services**. Service user involvement in the design and delivery of interventions is essential to ensure equity, acceptability, and relevance of services. Service user involvement should be standard practice. Efforts should be made to deliver high-quality comprehensive services in the community and on the streets, as well as in institutional settings such as prisons.

POLICY CHALLENGES

There are two overarching challenges for policy, that emerge from this research:

- **Structural changes to reduce child poverty**, or reduce prison populations require major shifts in politically driven public policy.
- **Achieving integrated multicomponent care** requires health, social care, housing and the voluntary sector to work closely together despite their seperate budgets and contradictory outcome targets. For example, investment in Housing First requires funding from housing, social care, community physical, mental health and addiction services. But the financial savings accrue in criminal justice and secondary care.

References:

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