Abstract

Purpose – The purpose of this paper is to provide an exploratory account of the links between devolution, homelessness and health in the UK. Specifically, it focusses on the policy context and governance structures that shape the systems of healthcare for homeless people in London, Scotland, Wales and Northern Ireland.

Design/methodology/approach – Empirically the paper draws on semi-structured interviews with a small sample of policy and practice actors from the devolved territories. Qualitative interviews were supplemented by a comparative policy analysis of the homelessness and health agenda within the devolved regions. Theoretically, it takes inspiration from Chaney’s concept of the “issue salience of homelessness” and explores the comparative character of healthcare as pertains to homeless people across the devolved territories.

Findings – The paper provides clear evidence of areas of divergence and convergence in policy and practice between the devolved regions. These features are shown to be strongly mediated by the interplay of two factors: first, the scope and scale of national and local homelessness prevention strategies; and second, intra-national variation in public health responses to homelessness.

Originality/value – The paper offers considerable insight from a comparative policy perspective into the nature of healthcare provision for homeless people in the devolved regions.

Keywords Public health, Health, Welfare, Homelessness, Devolution, Homeless people

Introduction

There is a growing acceptance within UK academic and policy circles that homelessness is as much a health issue as it is a matter of housing (Hewett and Halligan, 2012; Homeless Link and St Mungo’s, 2012). In England, for example, this concern is most clearly associated with the Department of Health’s Homeless Hospital Discharge Fund and the Pathway model of integrated care for single homeless people and rough sleepers (Department of Health, 2013; Pathway, 2014). For Scotland and Wales this changing landscape has been powerfully articulated through the publication of the Health and Homelessness Standards (Scottish Executive, 2005) and Standards for Improving the Health and Well-being of Homeless People and Specific Vulnerable Groups (Welsh Government, 2013), respectively. Northern Ireland has witnessed the emergence of a number of local policy measures that seek to link housing, health and social care (Public Health Agency (PHA), 2013).
This step-change in praxis is part of a broader assemblage of policy concerns linked to an increasing emphasis on health inequalities and localism. These interlocking webs are further complicated by wider debates about the economic costs of emergency care, hospital discharge and intermediate care for homeless people (Hendry, 2010; Albanese et al., 2016; Dorney-Smith, 2011). This unfolding terrain has created the conditions for a more nuanced appreciation of the deleterious health effects of homelessness. It has also enabled local policy actors to actively (re)shape healthcare provision for homeless people. We suggest that one potentially productive way to make sense of the complex relationship between health and homelessness within the UK and between its constituent parts is through the combined analytical unit of devolution and what Chaney (2013) has referred to as the “issue salience of homelessness”.

For Chaney the concept of “issue salience” provides an explanatory framework for understanding the prominence and attention given to homelessness policy in UK electoral campaigns. As such:

[Its] utility to comparative welfare studies lies in its presentation of a temporal perspective of parties’ issue definition and political prioritization of welfare issues, as well as how frames as narrative devices develop and become more or less prominent and persuasive over time (2013, p. 29).

Eschewing Chaney’s explicit focus on the party politicisation of homelessness policy, we argue that the concept of issue salience provides a useful entry point for understanding how policy and practice in relation to the healthcare needs of homeless people are linked to devolution and broader reconfigurations in public policy. Three points are important here. First, it enables us to locate the issue salience of homelessness within the prevailing policy-making structures and political agendas extant in each of the UK’s component territories (Watts, 2013; Fitzpatrick et al., 2012). Second, it allows us to identify the dynamic interplay between policy formulated at the centre and the way in which it is interpreted and implemented by local institutional actors. Overall, we suggest that the concept of the “issue salience of homelessness” serves to reveal how the coupling of homelessness and health is increasingly variegated in terms of national, regional and local policy and practice coverage.

This paper is structured into a number of parts. The first part begins with an overview of the devolved structures of government in the UK. The second part provides a description of the methodology. Each subsequent part then focusses on a particular territory through reference to: devolved powers in respect of homelessness and healthcare; and intra-national variation in public health policy responses to homelessness. Incorporating empirical findings, these strands allow us to critically reflect on processes of convergence and divergence in homeless healthcare across the component territories of the UK.

Methodology

Data were collected using semi-structured interviews with key informants from the devolved territories. Informants were recruited via purposeful sampling. This strategy was informed by a desk-based search of the leading organisations and information-rich (Palinkas et al., 2015) individuals working in the overlapping spheres of health and homelessness in each territory. In an effort to secure active and meaningful participation, we entered into a series of e-mail and telephone exchanges with a small, but highly knowledgeable group of policy and practice actors in each region. This approach served two important functions. In the first place, it enabled us to outline the purpose of the study and therein demonstrate our research credentials and intellectual curiosity (Stephens, 2007). In the second place, it allowed us to gain a commitment from key informants’ to participate in the study and thereby engendered rapport building (Goldman and Swayze, 2012). The use of telephone interviews as a data collection method facilitated access to geographically dispersed research participants in short order. Interviews were conducted by telephone. Three interviews were conducted in London (local government representative, homelessness nurse, Greater London Authority representative); five in Scotland (Scottish Government representative, homelessness nurse, Greater London Authority representative); five in Scotland (Scottish Government representative, homelessness nurse, Greater London Authority representative); four in Wales (homelessness nurse, Welsh Government representative, local government representative, Health Board representative); and five in Northern Ireland (Public Health Agency (PHA) representative,
homelessness nurse, Housing Executive representative, service manager, third sector executive. Ethical approval was granted by the researchers’ home institution.

In addition to qualitative interviews, we sought to gain a fuller understanding of the homelessness and health policy environment through a comparative analysis of extant policy documents and strategic guidance. This research tactic opened up a space through which to better arrive at a context-contingent understanding of policy formulation and practice implementation in each devolved territory (Collins, 2005). At critical points in the research process, the comparative policy analysis informed the development and focus of the interviews, while completed interviews influenced further analysis and exploration of the wider policy process. As will be demonstrated, this recursive process led us to take inspiration from the conceptual carapace afforded by Chaney’s notion of the “issue salience of homelessness”.

All interviews were audio recorded. Recordings were transcribed verbatim and imported into the Atlas.ti 7 qualitative data analysis programme. Thematic analysis was conducted on the interview data. Themes identified were as follows: the scope and scale of national and local homelessness prevention strategies; and intra-national variation in policy, practice and governance in relation to health and homelessness. Primary research was undertaken between March 2013 and February 2014.

**Devolution: structures and governance across the UK**

Devolution has been one of the most transformative changes to the territorial governance of the UK state in its history. Properly understood, political devolution embodies a process by which power is devolved from the central state to elected sub-national scale governments (Bogdanor, 1999). For most aspects of domestic policy, the UK now has four separate territorial governance and legislative jurisdictions (i.e. England, Northern Ireland, Scotland and Wales). It is important to note that the UK system of devolution is described by constitutional scholars as asymmetric (Leeke et al., 2003), in that the package of powers devolved are specific to each territory creating a variable geometry of devolution.

**Homelessness and health in London**

In England the coupling of homelessness and health has attained a significant presence in public health policy and service delivery, particularly in relation to efforts to improve hospital admission and discharge arrangements for homeless people (Whiteford and Simpson, 2015). In 2011, the Faculty for Homeless Health[1] published the Standards for Commissioners and Service Providers, the first comprehensive set of Standards for health services for homeless people in England. Additional momentum came from the statutory duty placed on NHS commissioning organisations to reduce health inequalities, as required by the Health and Social Care Act 2012. In 2013, in the context of the growing focus on addressing health inequalities, a revised set of Standards was produced[2] to encompass other vulnerable groups (e.g. sex workers and migrants) as well as homeless people. This heightened awareness was reflected in the Department of Health’s decision to establish the Homeless Hospital Discharge Fund (2013-2014), the first government supported fund of its kind in the UK. From a broader perspective, specialist primary care services, homelessness organisations and enhanced care providers such as Pathway (the homeless health charity) have been instrumental in driving forward improvements to healthcare services for homeless people. Exemplifying the bottom-up nature of these developments in England is London, which occupies a pivotal position in the innovation of healthcare interventions for homeless people.

What differentiates London from the rest of England is the scale of “visible” homelessness on one hand, and the difficulties associated with commissioning and coordinating services across local boundaries on the other (Akbur, 2015). The 32 London boroughs and the City of London operate on the same statutory footing in respect of homelessness legislation as the rest of England, although the Mayor of London is responsible for commissioning Pan-London services for rough sleepers. Under these conditions, the independent London Health Commission was established
in 2013 by the Mayor to examine how London’s health and healthcare could be transformed. The Commission issued a list of ambitions and recommendations including:

Health and care commissioners should develop a Pan-London, multi-agency approach to healthcare for the homeless and rough sleepers, with dedicated integrated care teams, and commissioned across the capital by a single lead commissioner (Recommendation 31).

The most obvious expression of this is the work of the Pan-London Homeless Health Services Programme. In practical terms, the Homeless Health Services Programme Board aims to work with service commissioners and healthcare providers to design, pilot and implement a multi-agency, single CCG-led commissioning model. Lambeth CCG (with the local authority) and Central London CCG have been jointly appointed as lead commissioner for this work.

As a region with specific governance and commissioning systems in relation to healthcare (Mehet and Ollason, 2015), London stands apart from the rest of England. This distinctiveness can be seen in all 32 of London’s CCGs agreeing to pool 0.15 per cent of their budgets to create a shared fund to support a series of healthcare improvements. Of the 13 programme strands, one is explicitly concerned with improving homeless healthcare services. A GLA representative argued that the Mayor’s commitment to improving the health of homeless people was congruous with wider efforts to tackle health inequalities, thus:

Health is a priority and rough sleeping is a priority. The Mayor has a bigger role in the health, more sort of statutory defined role with the Health and Wellbeing Boards, but again actually no funding, so it’s difficult to understand exactly what that means in reality. We did get reference to homelessness and rough sleeping into the Mayor’s inequality strategy and if that is refreshed, and I believe it is going to be, and I would want it to be in there because if there is any client group that you know reflects the most acute inequalities in health provision it has got to be rough sleepers.

Within the parameters of the circumscribed powers available to the GLA, the Mayor has supported a small number of specialist healthcare initiatives for homeless people to develop a city-region wide policy dimension:

We have done some really good things. I don’t think we have had a strategic impact on health policy or health commissioning very directly. However, we have funded London Pathway [and] a peer health-mentoring project that is around treatment adherence. We have just launched a mental health service intervention for rough sleepers and that’s about the appropriate use of mental health assessments and mental capacity assessments of people who are largely deemed by some services as making a lifestyle choice […] [They] are the good things and I suppose in a way they are in the world of health quite small but I think that’s where we’ve had more impact than sort of trying to effect greater change (GLA Policy Officer).

As the above extract illustrates, the GLA has adopted a targeted approach to health and homelessness agenda by aiming to fill-in policy gaps and add-value through enhancing specialist service provision on a cross-boundary, Pan-London basis, as the GLA policy officer reflected:

I’ve been doing the work around health for five years, whether we [GLA] have achieved a single thing I don’t know. We will have achieved some stuff just by commissioning some people to fill those gaps but can we change their health?

By utilising the limited policy and funding discretion available to it in the health and homelessness arena, the GLA has sought to intervene in an area of policy that largely falls within the remit of the London Borough authorities and health service providers. In the context of London’s layered local governance structure (with 32 Borough Councils and the City of London) and complex health and social care commissioning system, the GLA has been able to develop strong partnerships and working relationships but there is a recognition that its capability to influence health policy and reshape service provision on the ground is limited:

[Our] relationships are pretty positive and they are one of partnership […] rather than authority over the boroughs. We don’t have a sort of statutory lever in this area […] it feels impossible in a way to influence because of the localisation of structures, the commissioning structures and those sort of top-down approaches – very difficult […] and probably beyond the resource we have (GLA Policy Officer).

It is important to recognise that the dual track of welfare reform and public sector financial austerity have created new challenges for public health and social care systems across the UK. This has been felt particularly keenly in London where these factors have intersected with a
severely constricted housing market. Together they have contributed to a situation in which several London boroughs have been unable to meet their statutory duty to applicants who are homeless and in priority need, thus leading to homeless people being “exported out” of the capital (Garvie, 2012). Despite these new and ongoing challenges particular to London, the essential point remains, however, that the issue salience of healthcare for homeless people has been high, featuring prominently in the thinking of policy-makers in the capital and as a site for interagency co-operation and allied funding. As such, it has compelled the GLA to develop targeted city-region policy responses to emergent health and homelessness challenges.

Homelessness and health in Scotland

Scotland has been in the vanguard of homelessness policy and practice in the UK (Fitzpatrick et al., 2012), exemplified by the abolition of the priority need criteria in 2012. This progress stimulated activity in the corresponding environs of health and homelessness. In 2001, the then Scottish Executive appointed a Health and Homelessness Coordinator (known as a Czar) and in the same year the NHS Health Boards were required to produce health and homelessness action plans for service improvement. In 2003, the health needs of homeless people were recognised as part of a broader health inequality strategy.[3]. This interest reached its zenith when the Scottish Executive produced a set of Health and Homelessness Standards in 2005, although the role of Health and Homelessness Coordinator was abolished. The Standards are essentially corporate strategic priorities designed to guide the Health Boards, particularly in terms of encouraging strong local leadership in relation to the homelessness and health agenda. As such, the Standards are strategic rather than clinical in focus and are primarily concerned with tackling health inequalities through partnership working. The Standards were presented as being contiguous with Scotland’s ground-breaking approach to tackling homelessness:

These Standards are a key component of the Scottish Executive’s holistic approach to preventing and alleviating homelessness. [...] the Executive is determined that by 2012 everyone in Scotland who is homeless will have the right to a home, and that the necessary support and healthcare people need to realise their potential will be in place (Kerr and Chisholm, Ministerial Foreword, 2005, p. 1).

The existence of a strong statutory safety net alongside a muscular commitment to ensuring that homeless people have equitable access to healthcare services was seen to mutually reinforce the issue salience of homelessness in Scotland. For others, though, the health and homelessness agenda was understood to have waxed and waned in intensity and influence over the past decade, as the following extract makes clear:

The national health and homelessness steering group had a health and homelessness Czar, and its focus and activities were quite intense. After a couple of years, particularly when the performance assessment was withdrawn, that level of activity dropped because there was no organised central monitoring system (Homelessness policy coordinator).

A key reason for this was the decision by the SNP Government to end the requirement on the Health Boards to report progress on implementation of the Standards, as part of a “light-touch governance” agenda aimed at reducing the administrative burdens placed on local organisations. This was a key factor that led to policy drift:

I think the Government has been a bit slow and [...] it has kind of dropped off and gone away. The [local] steering group has got together and they have met three times now; so we’re hoping that it is going to bring back up a further drive in health and homelessness. I think in Scotland we have some really astute people in fairly senior positions who have got a real drive and want to make sure health and homelessness is kept on top of (Homelessness and Health manager).

In an effort to counter this policy drift, a number of new initiatives were initiated at a national level. In August 2011 the Health and Homelessness Steering Group convened a national health and homelessness conference in an effort to “re-invigorate the Health and Homelessness agenda” Coalition of Care and Support Providers in Scotland (2013) by bringing together key policy players in this field. Despite this, progress on the ground was relatively slow and it was not until 2015 that there was renewed impetus following the publication of the Scottish Public Health Network’s report Restoring the Public Health response to Homelessness in Scotland.
Overall, this recent resurgence of policy interest may indicate that the issue of health and homelessness will henceforth receive a higher level of prioritisation by NHS Health Scotland, Health Boards and other allied organisations operating in this field. Indeed, indicative of this is Health Scotland’s decision to include homelessness in its 2015-2016 workplan Hamlet and Hetherington (2015). However there is a sense of déjà vu, as Scotland has been at a similar stage before in the development of homeless healthcare and whether this new momentum can be maintained will depend on the sustained commitment from pivotal policy drivers, especially Ministers, Health Boards and Directors of Public Health.

Homelessness and health in Wales

In recent years, the Welsh Government have moved to embrace the so-called “preventative turn” (Mackie, 2015) in homelessness and housing policy. The Housing (Wales) Act 2014 enshrined the centrality of preventive measures, while also outlining the establishment of a stronger safety net for homeless people (Fitzpatrick et al., 2015). Developments in housing and homelessness have been complemented by improvements in health services. The most notable expression of this direction of travel is contained within the Welsh Government’s Standards for Improving the Health and Well-being of Homeless People and Specific Vulnerable Groups (2009). Strategically, the Standards provide a framework for partnership working within the seven local Health Boards in Wales. Operationally, the Standards place a requirement on each local area to produce a Homeless People and Vulnerable Groups’ Action Plan (HaVGHAPs), which is in effect a tool to implement the health and homelessness agenda on the ground. Broadly speaking, each HaVGHAP is fundamentally concerned with identifying local health needs and facilitating access to healthcare. This focus on “local adaptation to meet local needs” has resulted in widely divergent levels of progress and provision. Reflecting on this variance a Public Health Wales official attributed the uneven implementation of the HaVGHAPs/Standards to the levels of general awareness and acceptance of the health needs of homeless people – and the issue salience of homelessness – among local Health Boards:

[...] the disparity is quite huge at the moment; some Health Boards are not even aware of the Standards and then there are other Health Boards where they have got their own task and finish group. They have individuals from the third sector, primary, secondary care, public health, local authority; and they are actually working towards [implementing] the Standards, if not surpassing the Standards as well. Unfortunately, there isn’t standardisation throughout the country (Welsh Government representative).

Similarly:

This was one of the requirements of the Government in Wales that all Health Boards must have a HaVGHAP. We’ve all now done that, but we were ahead of the game (Health Board representative).

A local government representative articulated a more critical viewpoint, which spoke of a tension between the centre and the periphery:

We set up a HaVGHAP steering group and we did produce something that did go into the Welsh Government, but there was a deafening silence and then some considerable time later someone from Public Health Wales was given the task of going around and talking about the HaVGHAP and what have you. When they came to [see us], she started-off with “you haven’t been able to produce a HaVGHAP yet”. “But yes we did and here it is, and it went to the Welsh Government. Actually we have done something [...] although we’re not as far along with it as we would like to be, and perhaps we’re not doing as much as could be done in this area and we have to be pragmatic”.

There was also a sense of disconnect between the ambitions of the Standards and the local reality of identifying and responding to complex needs, as the local government representative went on to explain:

It really is a very poorly deprived Health Board area, so there are huge issues facing the general population as a whole as well as these particularly vulnerable groups. It means that it is very difficult agenda. We don’t have any specific locally enhanced services for primary care to provide services that other Health Boards probably do have. [We] are trying to tackle the issues as best we can with a range of partners.

In recognition of these difficulties in the local implementation of the Standards through the HaVGHAPs Bradley (2015) and other changes in the wider environment of homelessness,
in particular the upward trend in homelessness since the end of 2009 Welsh Government (2013), policy-makers in Wales sought to refresh the health and homelessness agenda. In 2013 Public Health Wales along with the Welsh Government produced the guidance document Standards for Improving the Health and Well-being of Homeless People and Specific Vulnerable Groups, which signified an attempt to update and revamp the original 2009 Health and Homelessness Standards. This guidance document was designed as a “template” for use by Health Boards and their partners to demonstrate the impact of the Standards in addressing health and homelessness in local areas.

Critical to this new approach was a recognition of the need to strengthen reporting mechanisms in relation to health and homelessness policy implementation, through a “proforma” that could be used to assess the local impacts of the standards:

This focuses largely on process and it is envisaged that initially reporting on progress will be largely narrative. It is proposed that reporting would be at Health Board level via the Health of Homeless People advisory group. Summary reports would then be provided to Welsh Government on a regular and ongoing basis (Welsh Government, 2013, p. 6).

In order to establish formal linkages with wider health policy, this reporting process also forms part of the NHS Outcome Framework (Ellis, 2015). The need for enhanced monitoring and clearer lines of reporting was also brought into stark relief due to an acute lack of key data and intelligence on the extent and impact of homelessness in Wales, as the guidance document acknowledges:

It is also the case the number of homeless people in Wales is currently unknown and there is no current dataset, which can be used to measure health and wellbeing in this group (Welsh Government, 2013, p. 6).

It is too early to make a considered assessment of the effectiveness of this new progress reporting system in Wales. However, the first Welsh Government “progress report” (2013/2014) stated that “good progress” had been made by the Health Boards on the implementation of the Standards (Bradley, 2015). The progress report also identified four issues that required further action: the continued lack of high quality baseline health and homelessness data; further work on the Public Health Wales Hospital Discharge Protocol; the need for the Health Boards to increase service user involvement in this area of policy; and ensuring that all Health Board areas have in place agreed and implemented HaVGHAPs.

By placing a stronger emphasis on homelessness prevention and a concomitant focus on improving health outcomes for homeless people, the Welsh Government have ventured to embed the issue salience of homelessness within the crosscutting policy arenas of housing and health. As with Scotland, progression of the health and homelessness agenda has not been linear or smooth. The development of enhanced reporting mechanisms aims to strengthen national oversight of the health and homelessness agenda and stimulate greater consistency and standardisation in local policy implementation across Wales. Interestingly, the case of Wales also demonstrates how the logic of devolution and intra-national policy learning has emboldened the administration in Cardiff to pursue a policy agenda that is broadly akin to that espoused by its counterparts in Edinburgh.

Homelessness and health in Northern Ireland

Over the last five years, Northern Ireland has witnessed a period of sustained policy activity in the field of housing and homelessness (Fitzpatrick et al., 2014, p. 9). This reconfigured landscape is clearly legible in and through the Homelessness Strategy for Northern Ireland 2012-2017. The underlying rationality of prevention, based as it is on Scotland’s Housing Options model, has stimulated a realignment in local and national understandings of homelessness, while also serving to close the gap in policy and programmatic developments between Northern Ireland and the rest of the UK.

Contra to England, Scotland and Wales health and social care systems in Northern Ireland are fully integrated. Health and Social Care Trusts provide acute and hospital-based services and a variety of community-based social services, while the Health and Social Care Board is a
Pan-Northern Ireland commissioning body. Relatedly, the PHA has a mandate to tackle health
inequalities and works in alliance with Health and Social Care Trusts to promote the healthcare
needs of homeless people through partnerships with local statutory, community and voluntary
sector partners.

The Promoting Social Inclusion Homelessness Steering Group – a special interest group
covened by the Northern Ireland Executive – has a longstanding interest in promoting the
social inclusion of homeless people. As part of its work, the Steering Group produced a
strategic paper aimed at encouraging closer collaboration between government departments
and voluntary sector organisations in an effort to improve the health and well-being of people
experiencing homelessness. One of the sixteen guiding principles contained within the strategy
document was:

To promote the health and mental well-being of the homeless and ensure they have access to quality
health and social services when required; consider rolling out existing models of good practice across
Northern Ireland at a level proportionate to the incidence and risk of homelessness in each Health and
Social Services Trust area (2007, p. 4).

In recognising that homeless people experience significant inequalities in health, the Regional
Working Group on Health and Homelessness was established by the PHA (2013), and is
composed of statutory, community and voluntary organisations. It was widely viewed as a
positive advance, although there was also a corresponding recognition of significant gaps and
inconsistencies in homelessness service provision across the region:

Our client group continually falls through the gaps. They don’t meet the requirements for any team;
no team will take on responsibility for our service users. We are trying to drive forward a pathway of
care, [but] it really is sheer frustration. We continually fail to do that (Service manager).

The uneven geographies of homelessness provision (Cloke et al., 2010) would seem to
point towards the cultural invisibility of homelessness in Northern Ireland. This is not to
suggest that homelessness was not regarded as a significant social issue impacting on, and
relating to, housing need and health equity. Rather, the relationship between health
and homelessness was seen to be an emergent area of strategic interest, as a PHA
representative explained:

[It has become more of an issue for us because I have recently had the Minister of Health ask me to
provide him with a briefing paper on homelessness. It has come to the fore all of a sudden in Northern
Ireland. The truth is that homelessness is quite hidden in Northern Ireland. We have few rough
sleepers. We have a few in the city of Derry and some in Belfast. Other than that most of our homeless
will be in hostels or hidden.

If Scotland and Wales have been outliers in the formulation of health and homelessness
policy, particularly in relation to the emplacement of national performance measures and local
strategic frameworks, then the pace of progress in Northern Ireland has been largely
incremental and localised in character. Importantly, though, the implementation of the Northern
Ireland Homelessness Strategy (2012-2017) has raised overall awareness of the complex
needs of homeless people and, in consequence, provided a platform for closer
collaboration between housing, health and social care across all strategic policy levels

Discussion

Our research strongly suggests that Scotland and Wales have pursued broadly similar policy
trajectories based on “light-touch” governance in the form of government guidance and strategic
direction embodied in health and homelessness standards frameworks and performance/
outcomes measures. These standards are not statutorily enforceable, with the administrations in
both countries keen to avoid imposing a centrally driven and prescriptive approach on local
actors. Nonetheless, policy-makers in both countries have sought to develop clear and arguably
ambitious national health and homelessness agendas.

Despite these ambitious goals, sustained political and policy community commitment has
been less evident in Scotland. A key reason for this was the Scottish Government’s decision to
lessen central direction over homelessness and health policy by ending the perceived burdensome performance monitoring requirements on the Health Boards. In effect, the implementation of the Standards and responsibility for driving forward the national health and homelessness agenda was devolved and entrusted to local policy actors, in particular the Health Boards. Perhaps inevitably policy implementation was fragmentary across Scotland, relying on the enthusiasm and innovative capacity of local actors to design their own locally specific service provision in response to local demands and pressures. In those areas where this has happened (e.g. Glasgow and West Lothian) innovative approaches have emerged, which stand out as national exemplars of good practice. The recent attempt to resuscitate this agenda is recognition of the failure to implement and embed a truly “national” health and homelessness policy across all the health board regions of Scotland. The Scottish case demonstrates that while a policy matter may initially achieve a high level of issue salience within the policy-making hierarchy, this does not necessarily translate into successful policy implementation on the ground without the sustained long-term leadership, direction and oversight from key political and policy actors.

Equally in Wales, ambitious national policy objectives did not translate into effective local delivery, as Health Boards were largely left to their own devices by the Welsh Government. Like Scotland, the initial governmental enthusiasm that instigated the drafting of the Homelessness and Well-Being Standards was not followed through with a clear national delivery strategy or sustained political commitment by the Welsh administration to drive this agenda forward. This was exacerbated by the failure to establish effective local reporting mechanisms that would allow the Welsh Government to monitor progress on delivery of the Standards across Wales. As with Scotland, concerted attempts have been made to re-energise the health and homelessness agenda, culminating in the publication of the Standards for Improving the Health and Well-being of Homeless People and Specific Vulnerable Groups 2013. Most significantly, the Welsh Government has now recognised the need to establish a framework of central oversight to track progress in the implementation of the Standards across Wales. Given these recent operational developments, arguably the policy-making community has learned from its earlier experiences and Wales is now on course to develop perhaps the most comprehensive and progressive approach to health and homelessness in the UK.

England has also traversed a broadly similar policy path in the development of healthcare standards for the homeless as adopted by policy-makers in Scotland and Wales. However, in England much of the initial impetus propelling these developments came from local non-governmental actors, especially healthcare professionals and organisations in London. Consequently, the issue salience of health and homelessness in the capital compelled the GLA to intervene in this area of policy – which was largely the responsibility of the London Boroughs and health authorities – and develop Pan-London solutions. However, the GLA has limited statutory powers and financial capacity in relation to health and homelessness policy and therefore it has only been able to focus on a small number of specialist homelessness healthcare initiatives. This bottom-up approach is a distinguishing feature of the English case. Unlike Scottish and Welsh Governments, at an English national scale, Westminster has not sought to establish a performance oversight system to monitor progress on the health and homelessness agenda, preferring instead to play a mainly supportive and advisory role and allow local policy actors to shape policy and drive service innovation.

In Northern Ireland the issue salience of health and homelessness agenda has been low, primarily due to the “invisibility” of homelessness in the region relative to other parts of the UK. This perhaps explains why Northern Ireland is the only territory that has not adopted a comprehensive standards and performance framework approach, and policy development overall lags behind Great Britain. However, despite the slow progress in developing specialist healthcare provision and protocols for homeless people, there are clear signs of increasing engagement with this agenda among senior policy-makers and service commissioners. Evident again in the Northern Ireland case is the recurrent theme of the pivotal role-played by dedicated individual local actors in driving healthcare improvements for homeless people in the region.
Few studies to date have investigated the relationship between health and homelessness from a comparative perspective (cf. Anderson and Ytrehus, 2012). We have sought to address this key lacuna through the prism of issue salience – understood here as a measure of relative weighting decision-makers assign to a given policy issue and its overall prominence within the wider policy-making and political agenda (Wlezien, 2005). Framed in this way, this exploratory account of the links between devolution, homelessness and health reveals some of the ways in which the devolved administrations in the UK are proactively seeking to find context-specific solutions to common problems. Recognising this leads us to suggest that the present study should therefore be viewed as a template for future research into this relatively under-examined, but critically important field of inquiry.

Notes

1. Now known as Faculty for Homeless and Inclusion Health Service.
2. The Standards document was written by the Faculty for Homeless and Inclusion Health Service.

References


Homeless Link and St Mungo’s (2012), *Improving Hospital Admission and Discharge for People Who are Homeless*, Homeless Link and St Mungo’s, London.


Further reading


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