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# Access to Health for People Experiencing Homelessness

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► **Abstract** *Homelessness significantly affects a person's health resulting in premature deaths and considerable suffering. Practice and policy remedies to improve health for people experiencing homelessness are based on the premise of the right to health. Implementing this right is commonly framed as a matter of 'access', for instance to health services or the social determinants of health (i.e., housing). Yet, there is limited consideration of the assumptions and practice implications of 'access' so understood. Engaging with scholarship from the social and health sciences, including public health, epidemiology, medicine, anthropology, and sociology, we identify three configurations of 'access to health': (i) the capacity to meet needs for health care; (ii) a means to govern people experiencing homelessness; and (iii) a means to reproduce socio-economic relations. We interrogate these configurations by discussing the concepts on which they draw, including fundamental causes, de/medicalisation, and citizenship. We propose empirically driven conceptual development to reimagine 'access to health' for people experiencing homelessness as rooted in the logic of care. The logic of care attends to how we think and feel about health, behaviours, and people, what is considered 'right' and what is – and ought to be – done to improve the health of people experiencing homelessness.*

► **Keywords** *Access to health, Homelessness, Social inequalities in health; Health policy; Logic of Care*

## Introduction

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People experiencing homelessness represent a growing part of the population in high income countries. Even prior to the COVID-19 pandemic, countries such as the United States, England, some European countries, and Australia have witnessed an increase in the proportion of the population who are homeless (Fitzpatrick et al., 2019; Pawson et al., 2020; NAEH, 2021; OECD, 2021). While the absolute number of people experiencing homelessness may be hard to verify, the links between homelessness and poor health are well-documented (Hwang, 2001; Baggett et al., 2010; Chin et al., 2011; Kertesz, 2014; Davies and Wood, 2018), including reduced life expectancy, as well as greater all-cause mortality (Seastres et al., 2020), and morbidity (Fazel et al., 2014). Homelessness is evidently associated with ill-health, including but not limited to cardiovascular disease and cancer, mental illness, accidental injury, respiratory illness, HIV/AIDS, sexual ill-health, and infectious diseases (Hwang, 2001; Kertesz, 2014; Kertesz et al., 2014). The access to health of people experiencing homelessness has been extensively problematised within a human rights framework (e.g., van Menxel et al., 2006).

The Constitution of the World Health Organisation (WHO, 1946, p.1) envisaged the “highest attainable standard of health” as “one of the fundamental rights of every human being.” Understanding health as a human right places the onus on governments to ensure access to timely, acceptable, and affordable health care of appropriate quality. At the same time, it situates health, including the health of people who are experiencing homelessness, within civic rationalities that assume an interplay of rights and obligations embedded in advanced welfare states (Parsell et al., 2021). As a human right, governments are compelled to provide for the underlying determinants of health, such as safe and potable water, sanitation, food, housing, health-related information, education, and freedom from discrimination (OHCHR and WHO, 2016). In turn, individual citizens ought to strive for their best possible health within their circumstances. This serves to situate the health for people experiencing homelessness increasingly within an economic calculus (van Leerdam, 2013; Wood et al., 2016; Lemoine et al., 2021). Here, the flow on effects of poor health in this population are framed as a strain on limited health care resources (e.g., acute services), and seeking improvements to their health is justified to maximise the utility of community resources (Doran, 2016).

The notion of ‘health as a human right’ often proffered by such cost-benefit analyses informs a multi-disciplinary scholarship in the social and health sciences, including public health, medicine, epidemiology, anthropology, and sociology, striving to improve the access to health for homeless people. Yet, explicit engagement with the underlying logic contained in ‘access to health’, is often limited. In this article, we identify and discuss three configurations of ‘access to health’ rooted in the logic

of choice (Mol, 2008). In doing so, we critically engage with key concepts such as de/medicalisation, fundamental causes, and citizenship to highlight opportunities for conceptual development. We propose a fourth configuration – access to health as a set of collective practices – based in the logic of care (Mol, 2008). Before we present our synthesis of prevalent configurations in the ‘access to health literature’ we outline the tensions between choice and care to guide our analysis.

## **Choice and Care in the Context of Health**

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The shifts in contemporary welfare systems and governance traced in the social and political sciences (e.g., Parsell et al., 2021) have been accompanied by similar paradigmatic changes in how health and health care are understood. The individualisation of responsibility for health and care is a key process here, as citizen consumers are charged with looking after their own health (Petersen et al., 2010). The underlying assumption links health outcomes to good individual practices based in informed and deliberate consumer choices. In other words, being healthy and living healthily is not only individually desirable but also normative to maintain a functioning citizen body. Negative health outcomes may be interpreted as a person’s failure to screen for and prevent ill-health, seek and follow timely medical advice, or more broadly to ‘live well’ (Crawford, 2006).

Mol (2008) argues that these dynamics follow the ‘logic of choice’. This logic assumes that individuals optimise their own health to the best of their knowledge with the help of medical experts. As citizen-consumers, their rights to health are contingent on taking ownership of how they live and making good choices. Mol (2008) contrasts this with a logic of care that makes sense of health as emergent in collective practices during situations of choice. In this way, the logic of care attends to the socio-cultural context (how we think and feel about health, certain behaviours, and people) as well as moralities (what is considered ‘good’). We argue for explicitly shifting towards a logic of care in research and practice seeking to improve the access to health for people experiencing homelessness, which acknowledges the social relations in which choices are negotiated. To build this argument, we outline and discuss three configurations of access to health informed by the logic of choice: access to health as (i) the capacity to meet needs for medical care, (ii) the governance of people experiencing homelessness, and (iii) the reproduction of socio-economic relations (see Table 1). The configurations of access to health for people experiencing homelessness discussed in this article are not mutually exclusive but integrate these three dimensions to varying extents, as we explore below.

## Access as the Capacity to Meet Needs for Medical Care

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*Unmet needs and barriers to health care:* There is a substantial body of empirical work conceptualising access as the ability to meet the need for medical care when required. In turn, the poor health experienced by homeless people becomes measurable by cataloguing their ‘unmet’ needs (Baggett et al., 2010) and the system and individual barriers to catering to those needs (Hauff and Secor-Turner, 2014). The catalogue of unmet needs spans reproductive health care (McGeough et al., 2020), foot care (D’Souza et al., 2021), dental care (Yokota et al., 2020), care after hospital discharge (Canham et al., 2019), mental health and primary care (Chambers et al., 2013), and scholars debate whether unmet need is a driver of unnecessary use of acute health care services (Doran, 2016). While “being homeless is difficult enough,” “accessing health care while homeless is even more daunting,” as Martins (2008, p.428) put it. Homelessness creates barriers to accessing mainstream healthcare, which exacerbates the underlying health problems of people who are experiencing homelessness, and in turn creates additional barriers for them to access and sustain housing (Parsell et al., 2020). It also illustrates the logic of choice (Mol, 2008), as individuals’ health service utilisation is scrutinised in terms of its barriers and enablers. The most commonly identified barriers to meeting the need for medical care are financial, e.g., ability to pay for service, fill prescriptions, arrange transportation, or compensate for loss of paid hours of work (Hwang, 2001; Zlotnick et al., 2013; Kertesz, 2014; Ramsay et al., 2019). The conclusions drawn from this understanding of access is that solutions are needed that work around the extended financial barriers to meet the specific health care needs of people who are homeless.

### *The role of health system models*

Unmet needs are deemed symptomatic of an ailing health care system in which the provision of care is contingent on market dynamics and a patchy health insurance system. Studies on the unmet needs of people who are homeless are concentrated in the United States, in which poor health insurance coverage is compounded by the emergence of an increasingly complex health care system that provides free or subsidised services to some marginalised populations, for example veterans experiencing homelessness, but not others. Concurrently, specialised homeless health services and outreach models (e.g., ‘medical homes’ or ‘pop-up clinics’) often attached to community health centres have emerged in parallel to mainstream health care services with the aim to remove barriers to accessing medical care faced by people experiencing homelessness (Kertesz et al., 2013). This has brought about a different set of issues about quality standards, patient-centredness, and continuity of care, as well as the potential exclusion from access to medical care of socially disadvantaged persons out of catchment or not specified in a community health centre’s funding model (Varley et al., 2020).

### ***Fundamental cause theory***

In contrast to the United States, countries such as Canada, the UK, Australia, and much of Europe have health care systems which incorporate both market and public welfare principles to provide universal health care (Hwang et al., 2013). These universal systems differ in important ways across countries and often health care coverage is not as comprehensive as the term ‘universal’ implies; nevertheless, these systems address many of the barriers identified in the United States. Yet, research demonstrates that health disparities for homeless people persist despite universal access to health care (Chin, Sullivan and Wilson, 2011; Davies and Wood, 2018; Seastres et al., 2020). Fundamental cause theory sheds light on the associations between health and socioeconomic status (SES) (Link and Phelan, 1995; Phelan and Link, 2013; Cockerham, 2021) and provides useful starting points to explain the poor health experiences of people who are homeless in countries with access to universal health care. SES is more than a background factor that sets the scene for biological and medical processes; it is a direct cause for differential health outcomes. Fundamental cause theory’s analytical rigour lies in its capacity to query why and how social structures promote health for some, but not others.

Four criteria serve to evaluate if social categories qualify as ‘fundamental causes’. First, the social category would be expected to influence the experiences of multiple diseases. Second, the social category would be expected to encompass varied risk factors and mechanisms through which disease outcomes are affected. Third, the social category would likewise be associated with differential access to resources that can be deployed to mitigate risks. Fourth, the social category would be expected to show a dynamic but persistent relation to health outcomes over time, even though biomedical knowledge and health care modalities might shift (Cockerham, 2021). Applying these criteria to the experience of homelessness as a specific socioeconomic status characterised by multiple resource constraints, risks, and patterns of disease incidence, indicates its role as ‘fundamental cause’. As discussed above, homelessness inflects the experience of many diseases (criterion 1). It also presents a swath of risks and potential mechanisms through which health is affected (criterion 2). Becker and Foli (2021), for instance, identified accessibility of services as only one of four critical attributes for homeless people’s health-seeking behaviours. They operationalised decreased access as “being uninsured or having no money, requiring transportation, experiencing long wait times for appointments, or lacking knowledge of available healthcare services” (Becker and Foli, 2021, p.4). Analytically, they differentiated ‘access’ from other salient mechanisms, such as distrust in healthcare services, prioritisation of more urgent physiological needs, and delayed care seeking within the critical attributes that impact health-seeking behaviours among homeless people.

### ***Limitations of access as capacity to meet health needs***

Experiencing homelessness also affects the capacity to mitigate risks through effective resource deployment (criterion 3). Cheezum et al. (2018) examined the restricted availability of health promoting resources such as nutritious food along with environments for safe physical activity. The relationship of ill health and the experience of homelessness remains pertinent over time (criterion 4). Gelberg et al. (1997), more than 20 years ago in their sample of people experiencing homelessness in LA, identified that non-financial barriers, such as the urgency of finding and maintaining the means of subsistence, contribute to delays in help-seeking behaviour that result in greater acute care needs. Unmet health needs for homeless people appear to persist – albeit in changing guise – regardless of the health system model. Approaching homelessness as a social category that constitutes a fundamental cause explains the evident endurance of health inequalities despite general advances in treatment modalities (e.g., for cardiovascular disease) and across different systems of health care (e.g., universal vs. pay-for-service). This is the point of departure for scholarship that interrogates the role of housing at the core of health inequities which we discuss next.

## **Access as a Means of Governing Homeless People**

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### ***Housing and health in relation***

Building on, and often utilising evidence produced by the empirical studies mapping the unmet needs of people experiencing homelessness, there is a thriving scholarship interrogating the role of housing in their health. Access to better health is here thought of as embedded in dynamics that transcend health care systems, requiring interrogation of the flow-on effects of housing for individual and population health. While the ‘unmet needs’ literature is rooted in biomedicine and its knowledge practices, approaches to housing and health to varying extents draw on the social determinants of health paradigm (see e.g., Marmot, 2005). Being housed is identified with the norm from which people experiencing homelessness are seen to deviate either due to the structural conditions in which they live, or due to their personal characteristics and behaviours. Access to health then manifests as a means of governing people who are homeless in providing or withholding opportunities for housing and care. Pathways in and out of housing become inseparable from health, as housing and health policy converge in practice. This point is exemplified in the debate on what needs to be addressed first to achieve better long-term outcomes for people experiencing homelessness: the lack of housing, or the individual circumstances and practices that are purported to cause ill-health, often framed conceptually as an issue of de/medicalisation (Mathieu, 1993; Lyon-Callo, 2000; Löfstrand, 2012; Wasserman and Clair, 2014).

### ***Medicalisation and demedicalisation***

Medicalisation is the process through which social ills become redefined to fall within the remit of biomedicine. Demedicalisation, in turn, denotes the countervailing process in which issues previously perceived as medical spill over into other areas of expertise. Health issues that are associated with substance use, diabetes, renal and liver disease are commonly cast as driven by behavioural causes (Vallgård, 2011). Homelessness – due to the extent to which psychosis and addiction have pervaded our understandings of what defines and explains homelessness (Knowles, 2000) – becomes medicalised by its socio-cultural approximation to related behaviours (Wasserman and Clair, 2014). In its medicalised form, homelessness ceases to appear as a problem of social inequality but is made amenable to the intervention of medical practitioners focussing on one individual at a time.

### ***Treatment First***

Behavioural causes are assumed to be emergent in individual lifestyle and are seen as subject to a person's responsibility. We see again at work, what Mol (2008) referred to as 'the logic of choice'. The logic of choice assumes autonomous citizen-consumers who make informed choices and are willing and able to live with the consequences of their choices free from paternalistic interference. This aligns with the tenet of individual responsibility that has informed decades of housing policies under the banner of 'Treatment First' (Rosenheck, 2021). From the Treatment First perspective, people experiencing homelessness presenting with health and behaviour issues need be made ready for stable housing. In this way, ill-health situates people experiencing housing instability with respect to moralities in which health appears as an achievement to be pursued in appropriate actions, what Crawford referred to as 'healthism' (Crawford, 1980): ill-health signals moral failings, here compounded by the failing to secure the basic conditions (i.e., housing) for the pursuit of better health. Concurrently, as Farrugia (2010, p.84) noted, "homelessness is associated with irresponsibility and moral failing", placing people experiencing homelessness in a double bind. It is not surprising then, that stigmatisation and an atmosphere of being unwelcome is reported as another non-financial barrier to accessing healthcare (Wen et al., 2007; Hauff and Secor-Turner, 2014). If the experience of homelessness is understood as a function of undesirable and individualised behaviours believed to exacerbate poor health practices, interventions targeting individuals to correct such behaviours and enable 'better' choices come logically prior to meeting housing needs. These interventions are charged with producing morally viable subjects who demonstrate capacity for self-improvement as the necessary condition for eligibility to care in adjacent service systems (e.g., welfare and housing) (Lyon-Callo, 2000).

## ***Housing First***

In the wake of Treatment First's failure to stem the escalation of homelessness and the societal and personal costs it incurs, a movement sustained by a political alliance of public health expertise, social science, and advocacy put 'Housing First' models on the agenda (Tsemberis and Eisenberg, 2000; Hwang, 2001; Rosenheck, 2021). Padgett et al. (2016) refer to the influence of Housing First as a paradigm shift. Housing First departs from more complex understandings of the relationship of housing and health in which social conditions loom large alongside medical considerations (Hwang, 2001). As a theoretical foundation, Housing First mobilises the social determinants of health framework popularised in Marmot's call for investigating the 'causes of the causes' (Marmot, 2005, p.1101; see Rosenheck, 2021). Greater attention is paid to the societal dynamics that keep people out of secure housing culminating in integrated models of supportive housing for people experiencing chronic homelessness (Evans et al., 2016; Wygnańska, 2016; Cheezum et al., 2018). Housing provision is thought of as an intervention with positive flow-on effects for health (Doran et al., 2013; Baxter et al., 2019). The empirical evidence that Housing First leads to better outcomes for people exiting homelessness across a number of domains, and in particular in the transition to stable housing, is encouraging. Yet, the evidence for the efficacy of Housing First for improved long term health outcomes is inconclusive (Baxter et al., 2019), and often focussed on recovery from substance use and mental ill-health, and on reducing costs from hospital or emergency department use (Henwood et al., 2013; van Leerdam, 2013; Wood et al., 2016; Kertesz and Johnson, 2017; Chhabra et al., 2020; Kirst et al., 2020; Lemoine et al., 2021). In other words, the focus remains on 'problem' behaviours and their health system consequences (e.g., presentation to acute care service providers) commonly ascribed to homeless populations.

## ***Limitations of access as a means of governance***

Despite evidence demonstrating Housing First's success achieving desired behaviour change by providing access to housing, the underlying rationale for the need to intervene through supportive housing models is not entirely dissimilar from Treatment First approaches. Wasserman and Clair (2014) do not see Treatment First and Housing First as opposing forces but as located within the same individualised (and medicalised) paradigm. The same paradigm that is informed by the logic of choice as outlined above (see Mol, 2008). Housing First inverts the continuum of care as "homeless service institutions nonetheless continue to focus heavily on treatment" (Wasserman and Clair, 2014, p.3). At the same time, Housing First programmes' capacity to address the structural drivers ('the causes of the causes') and promote large-scale societal transformation is limited. This critique has given rise to scholarship interrogating the role of the third sector in the governance of people experiencing homelessness, which we discuss below.



## **Access as a Means of Reproducing Socio-Economic Relations**

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### ***Housing as health care***

In a trend parallel to the ‘right to health’ discourse, we have seen a rise in ‘right to housing’ approaches (e.g., Watts, 2013; Crowley and Mullen, 2019) with mixed implementation strategies and often unanticipated consequences (Loison-Leruste and Quilgars, 2009; Anderson and Serpa, 2013; Anderson, 2019; Swope and Hernández, 2019; Clarke et al., 2020; Brown et al., 2021). The focus on housing as a social determinant of health has brought about a degree of conceptual conflation of housing with health, in which housing itself is at times positioned as health care (Fullilove, 2010; Doran et al., 2013). Scholars interrogating health and housing from a political economy perspective argue that this potentially distracts from larger social relations of exploitation, in which the access to health/housing is a means of reproducing such relations by invoking reciprocal rights and obligations. Neoliberal frameworks intent on behaviour change are limited to ‘fixing’ individuals and fail to address structural dynamics (Wasserman and Clair, 2014; Rosenheck, 2021). In this view, unmet housing and health needs of people experiencing homelessness are not accidental – nor undesirable – within neoliberal and market-oriented societies. They constitute an integral and productive part of the political economy.

### ***Chronic homelessness***

Willse (2010), for instance, argued that Housing First approaches relied on the social construction of a specific category of homelessness, those experiencing long-term and repeated homelessness, who based on an economic calculus are prioritised for housing and health care. Hence, Housing First interventions, despite good outcomes, are seen as motivated by their capacity to alleviate strains on collective resources without tackling the societal relations that sustain inequality. Rights discourses (to health and/or housing) are reduced to rationalisations of policy decisions based on cost-benefit analyses. As Evans et al. (2016, pp.255) warned, “access to a fundamental health determinant – housing – is not a matter of the state fulfilling individual rights; rather, it is modulated through the government of risk, by linking specific groups in the homeless population to unfavourable health and social care utilization patterns.” On a broader level, this underlines another issue inherent to the logic of choice: what is good for the collective is not necessarily good for the individual, and vice versa (Mol, 2002; 2008). “By problematizing homelessness in terms of costs rather than values (such as rights), some homeless groups may be vulnerable when the cost analysis does not come out in their favor” (Evans et al., 2016, pp.255). Homelessness itself is a dynamic experience and its severity and duration has become increasingly quantified in counting ‘episodes’ to establish the degree of ‘chronicity’ of a person’s homelessness, borrowing from

the language of biomedicine. In turn, a 'diagnosis' of chronic homelessness with a poor health prognosis has been used to 'triage' persons for fast tracking them into housing and treatment (Willse, 2010).

### ***Neoliberal critique***

Taking aim at how homelessness becomes medicalised in the process and the role of the service provider industry (Lyon-Callo, 2000; Willse, 2010; Löfstrand, 2012), proponents of this critique argue that the facilitation of access – ironically – is inextricable from the (re)production of homelessness. This reasoning is informed by the extensive critique of neoliberal governance which has seen the dismantling of welfare provisions and safety nets across the globe. Yet, the proliferation of neoliberal critique is increasingly met with scepticism. Bell and Green (2016) have cautioned that using neoliberalism as a conceptual framework in and of itself is insufficient to produce sophisticated accounts of public health dynamics. 'Neoliberalism' has come to be employed as shorthand to explain (almost) every ill, while causal directions remain often unclear, concrete mechanisms driving health inequities are underexplored and implications for system change remain vague. Similarly, critiques have been levelled at the reliance on medicalisation as a conceptual tool within neoliberal critique. Rose (2007, pp.700-701) concluded that "medicalisation has become a cliché of critical social analysis". He argued that medicalisation instead needs to be acknowledged as fundamentally shaping human life in contemporary society. In doing so, Rose identified medicalisation-as-cliché as perpetuating an obsolete nature/culture dualism that unduly inhibits analysis.

### ***Limitations of access as a means of social reproduction***

Critiques of neoliberalism and medicalisation expose a dilemma within the dominant portrayal of the link between homelessness and health. On the one hand, homelessness is represented to be a social pathology that becomes amenable to (medical/housing) intervention and to which biomedical terminology applies (e.g., 'homelessness chronicity'). As a social ill to be cured, the debate then revolves around whether to address somatic symptoms, such as mental or physical ill-health to make people experiencing homelessness 'housing-ready' (i.e., Treatment First), or whether to prioritise shelter and prepare the homeless for targeted interventions to improve their lives (i.e., Housing First). Both models bring into effect subjectivities through which governance takes effect: the 'chronically homeless' and the 'housed' or 'formerly homeless'. On the other hand, homelessness thoroughly and relentlessly demedicalises the contemporary human condition by constraining participation in the most taken-for-granted salutogenic practices (i.e., shelter, safety, diet, rest, hygiene) that greatly impact on longevity and morbidity as well as sense of meaning and purpose in survival (see e.g., Håkanson and Öhlén, 2016; Paudyal et al., 2020). Framing medicalisation as an issue of medical authority that is extended

beyond its legitimate remit bears the potential to put individual people experiencing homelessness at risk, and cut them off from care (Knowles, 2000). Homelessness and ill-health become normalised as their association aligns with the non-medical/natural axis. As Braslow and Messac (2018, p.1887) noted, “we have seen not only the abdication of medical responsibility for the life circumstances of severely psychotic people, but also a growing acceptance of homelessness and incarceration as legitimate fates for people whose psychotic behaviour violates social norms” (see also Knowles, 2000). To address the issues raised in this article, and account for the complexities in the health of people experiencing homelessness, we propose to reimagine access to health for people experiencing homelessness guided by the logic of care (Mol, 2008), which we elaborate below.

### **Reimagining Access to Health for Homeless People within the Logic of Care**

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In this article, we described how access to health care is configured in three different ways, each in turn associated with varied policy responses and different implications for practice. Nonetheless, there is overarching consensus that the ill-health of people experiencing homelessness continues to be a pressing social justice issue, a public health as much as a moral crisis (Baggett et al., 2010). In each of the three configurations discussed above, structural issues are salient. Structural issues are recognised as barriers in systems providing health care, in the interactions of the health care system with other societal systems involving the housing industry and third sector organisations, and in the way the health of people who are experiencing homelessness is embedded in broader socio-economic relations. However, these configurations of access to health are guided by the logic of individual choice. We present four arguments that favour a shift of emphasis from choice to care in research and practice aiming to improve the health of people experiencing homelessness. First, pathway thinking hinders rather than enhances the advocacy for people experiencing homelessness. Second, housing and health agendas overlap considerably, but are not reducible to one another. Third, what is considered right and good is emergent and adaptable in collective practices rather than a preestablished ideal that individuals are to pursue. Fourth, shifting the focus away from lifestyle choices that expose individuals to judgment and stigma towards ‘situations of choice’ navigated collaboratively among multiple social actors facilitates attention to the caring relations in which health is produced. Below we elaborate each of these arguments in turn.

### ***Pathway thinking***

Sustained focus on pathways in and out of homelessness constitute a core component in the current scholarship on the relationship between health and homelessness. This scholarship understands the pathway out of homelessness as inextricable from achieving better health and addressing deviant behaviours. We summarise four points of critique that have been raised with respect to Housing First as currently the most progressive intervention strategy informed by pathway thinking: (1) Housing First only gives housing to people because they are sick, not based on rights; (2) focusing on sickness is often motivated by reducing health costs; (3) giving severely sick people housing does not address the structural failures that produce chronic homelessness; and (4) often accessing housing after chronic homelessness does not improve people's health significantly (Padgett et al., 2016; Parsell, 2017).

We argue that these critiques are associated with the logic of choice that informs interventions such as Housing First and Treatment First. As Mol (2008) highlighted, the logic of choice is troubled by the fundamental assumption of linearity: a decision is made at a point in time, actioned and presumably leading to calculable consequences. Housing a sick person should lead to better health outcomes for them. Better health should lead to more stable housing. Better health and housing outcomes should relieve the burden on social and health care systems. Better health and housing outcomes should also relieve the moral pressure to resolve broader inequalities. Interventions should result in observable improvements in individual circumstances and collective health, yet the evidence is not as unequivocal as we would anticipate. We argue that this is not an issue stemming from the unresolved debate whether to focus on Housing First or Treatment First, but from the assumption of linearity in causal chains that is poorly aligned with the messiness of lived experience. The issue lies in framing this debate as one on the *direction* of causality. In contrast, an approach rooted in the logic of care, presumes that improvements necessitate tinkering (or indeed 'doctoring'), failure, unintended consequences, and learnings that are emergent in the back and forth of relational practices. Interventions need to provide scope for adaptation and flexibility within caring practices.

### ***Convergence in health and housing agendas***

The underlying assumption in Treatment First and Housing First approaches is that the needs for safe and secure housing and other resources to obtain good health can be ordered and ranked by urgency, as if some can come logically prior before others. An overly linear understanding of the relationship of health and its social determinants has the practical implication that housing and health interventions converge in practice and policy. This runs the risk to subsume (and defer) urgent

health needs to advances in the housing justice agenda. This does not imply that housing and health should ever be completely separated from one another. In fact, we argue for uncoupling the debate from 'pathway' thinking to enable taking the health of homeless populations seriously. For example, the pathway to homelessness for an individual may include drug use. However, there are many drug users, but most of them will not experience homelessness. Is it reasonable to assume then that focusing on drug use in supportive housing will result in an individual's stable housing thereafter? Undoubtedly, addressing drug use will have positive flow-on effects for a person's health in its own right, regardless of immediate or subsequent housing outcomes. Applying the logic of choice here leads to the assumption that a good outcome is evident when a person refrains from using drugs and secures stable housing. All practice is oriented towards achieving this ideal outcome in which health and housing are simultaneously addressed. However, the evidence base on the outcomes of supportive housing interventions highlights that while housing and health overlap, they are not reducible to one another. This distinction matters, as it acknowledges the complexities in the access to health for people experiencing homelessness, which is insufficiently addressed by short term interventions targeting primarily housing whilst offering varying degrees of support as an add-on.

### ***Housing and good health as normative***

Debating whether the causes of homelessness are behavioural, structural, or indeed a complex interaction of 'causes of the causes' (Marmot, 2005) lends further traction to social dynamics in which the entitlement to good health is to be earned through appropriate practices of the self. Being housed and healthy is situated as normal within contemporary medicalised Western societies against which the experiences of homeless people are compared and defined as deviant. Somewhat ironically, the reviewed approaches to access, centre on the network of responsibilities and rights in which individual people experiencing homelessness find themselves, but with little attention to how people experiencing homelessness actually *do* health. Indeed, this is perhaps a function of underestimating the agency of people experiencing homelessness (Parsell, 2018), either by denying their capacity for decision-making as citizen-consumers in the underlying logic of choice, or by denying their agency with reference to seemingly insurmountable power asymmetries in interactions with housing and health service providers in political economy perspectives. We argue that re-envisioned conceptualisations of access to health need to attend to the lived experiences of homelessness as a profoundly de-medicalising set of conditions in which taken-for-granted amenities that have resulted in substantial improvements in general population health are precarious, sometimes absent, and often hard fought. Thus far, 'access to health' understood as meeting needs for medical care has dominated, resulting in targeted

research concerned with the barriers and challenges for help-seeking and health system utilisation, with little attention to the everyday experiences of exclusion from good health. Based on this, we argue for a research agenda pursuing a different set of questions: What does health mean for people in these circumstances? How do these meanings shift as people move along the continuum of housing instability? How do people enact health in everyday practices on the margins of society? How are these practices embedded in social relations?

### *From 'lifestyle choices' to 'situations of choice'*

We caution against (mis)taking the above questions as a call to centring the individual experiencing homelessness in research on health and homelessness, perpetuating the fallacies of the logic of choice. First, taking 'the homeless person' as object of enquiry denies the ambiguities concealed in the concept (see Parsell, 2018). Whether a person is considered homeless depends on local and socio-historical norms, that vary within and across countries (OECD, 2021). Internationally, definitions vary in significant ways, including the presence or absence of a disability (NAEH, 2021), one's ability to exert control over the environment (Pawson et al., 2020), or the absence of domains that constitute a home (Amore et al., 2011). The shifting definitional boundaries drawn around homelessness along a continuum of housing instability often encompass vastly different experiences, including those with respect to health (Parsell et al., 2020). Homelessness intersects with a range of subject positions across various contexts, including for instance, 'welfare recipient', 'single parent', 'casual worker', and 'victim of domestic or family violence', just to name a few. Concurrently, social inequalities predispose different parts of the population to be more likely to experience poor or unstable housing conditions and feel the effects on their health more severely (Ranmal et al., 2021).

Health inequities affecting people experiencing homelessness do not eventuate solely in the encounters with the health care system, but in the ordinary exclusion from enjoying the benefits of biomedical knowledge practices that pervade contemporary society. This is perhaps nowhere more evident than in the unfolding COVID-19 crisis. The pandemic has brought into sharp relief the conditions of homelessness that produce poor health and the profound inadequacies of our current homelessness and health responses. In many parts of the world, these limitations, and the urgent health problems that homelessness represents, have been responded to with swift action to minimise the health consequences of homelessness. Indeed, Parsell et al. (2021) argue that government response to homelessness during COVID-19 are motivated by the concern that people who are homeless represent a health risk to the broader population. The COVID-19 responses to homelessness exemplify an occasion where individual and population health agendas align, serving as a timely reminder for the embeddedness of health and

care in socio-historical context. These responses are a case in point for 'situations of choice' in which individuals' access to health (including social determinants of health, such as housing) is negotiated in collective practices.

We propose to understand the access to health for people experiencing homelessness as emergent in 'situations of choice' between different salient forces and social actors. Focusing on situations of choice allows for attention on how salient subject positions are enacted with implications for housing and health. It allows differentiated practices of care that address a specific need in its appropriate context over time as service providers and people experiencing homelessness collaborate to identify possibilities for intervention within the material constraints and affordances of lived experience. In this way, choice is not a matter of individual lifestyle, but is produced in social relations with a gamut of contingencies, intended as well as unintended consequences.

## Conclusion

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Improving the health of people experiencing homelessness presents an urgent priority, cutting across (i) *health system models*, (ii) *social determinants*, including housing as well as, (iii) *socio-economic relations* articulated in rights and obligations. We highlighted how the logic of choice informs configurations of the access to health for people who are experiencing homelessness variably as meeting needs for medical care, as a means to govern them, or as a means to reproduce socio-economic relations. We propose to move towards a logic of care that allows attention to 'situations of choice' as situated enactment of caring relations sensitive to cultural and historical context as well as dynamic over time. Our proposed focus is on how health is enacted, sustained, systematised, and stabilised in everyday and professional practices of care (see Mol, 2002), in a way that denies people experiencing homelessness good health. This requires research, practice, and policy to interrogate discourse and narrative, affect and emotion, as well as moralities. What we think and how we talk about health and homelessness, how we feel about certain parts of the population, certain behaviours, and the manifestations of (ill)health, as well as what is considered 'good and right', are the interrelated foci for progressing the analysis. These dimensions all bear on individual and collective practices and need to be addressed in conjunction. A practice sociology that acknowledges the embeddedness of social relations, discourses, and embodied experience is well positioned to advance this research agenda to generate evidence for social and health policy. Policies and programmes must prioritise the health of those experiencing health inequities most acutely.



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## Tables

**Table 1 – Configurations of Access to Health**

Configuration	Logic of Choice			Logic of care
	Means of meeting medical needs	Means of governance	Means of reproducing socio-economic relations	
<b>Key tenet</b>	Barriers to health service use drive differential health outcomes.	Housing and health are inseparable from behaviour change.	Service sector and governments perpetuate the social conditions for homelessness.	Socio-political context, cultural values, individual and population level relations inflect health practices.
<b>Questions</b>	How can <ul style="list-style-type: none"> <li>• <i>material</i> (e.g., fees, hours of work lost, transport)</li> <li>• <i>behavioural</i> (e.g., help-seeking)</li> <li>• <i>social</i> (e.g., stigma and shame)</li> </ul> barriers be addressed?	What is the best approach to address housing and health? <ul style="list-style-type: none"> <li>• <i>Housing First</i></li> <li>• <i>Treatment First</i></li> </ul>	What are the consequences of neoliberal governance? <ul style="list-style-type: none"> <li>• <i>Medicalisation</i> of chronic homelessness</li> <li>• <i>Demedicalisation</i> of psychiatric disorders</li> </ul>	How do people enact health in everyday practices on the margins of society? How are these practices embedded in social relations?
<b>Analytical focus</b>	Health systems	Social determinants of health	Rights and obligations in the neoliberal political economy	Situations of choice embedded in socio-cultural context