



Homelessness, health and the policy process: A literature review

Brendan Clifford*, Andrew Wilson, Patrick Harris

University of Sydney Menzies Centre for Health Policy, Faculty of Medicine & Health, Sydney 2006, Australia



ARTICLE INFO

Article history:

Received 17 December 2018
Received in revised form 14 August 2019
Accepted 19 August 2019

Keywords:

Homelessness
Political science
Policy process
Intersectoral working
Social determinants of health

ABSTRACT

Homelessness has serious consequences for the health of people experiencing homelessness, and presents a challenge to the provision of quality care by health services. Policymaking to address homelessness, as with other social determinants of health (SDH), is complicated by issues of complex causation, intersectoral working and the dominance of biomedicine within health policy. This paper investigates how policies addressing homelessness have been explored using formal policy process theories (PPT). It also examines how health (as an actor and an idea) has intersected with the issue of homelessness reaching policy agendas and in policy implementation. A systematised search of academic databases for peer-reviewed literature from 1986 to 2018 identified six studies of homelessness policy change from Australia, Canada, France and the United States. PPT were able to articulate the interplay of actors, ideas and structures in homelessness policymaking. When the health sector was involved, it tended to be in terms of healthcare service utilisation rather than a broader public health framework emphasising structural social determinants of homelessness. Tensions between differing the priorities of local homelessness actors and a biomedical evidence-based policy paradigm were noted. Future policy action on homelessness requires new models of intersectoral governance that account for the complexity of health determinants, a health workforce enabled to engage with the SDH, and meaningful inclusion of those with lived and living experience of homelessness in policy formulation.

© 2019 Elsevier B.V. All rights reserved.

1. Background

Housing has been a focus of public health since its foundation as a discipline, with people who experience homelessness being of particular concern due to the existence of serious health and social inequities [1,2]. Housing quality has a direct effect on health [3,4], and the effects of homelessness on health are particularly serious. Mortality rates of people who are experiencing homelessness in high-income countries are typically two to five times those of the general population, and result from a range of causes including infection, cardiovascular disease, substance use disorders and injury [5]. A well established body of evidence shows the importance of social determinants of health (SDH) such as housing [4,6], education [7,8], employment [9,10], and social position [11–13] to health outcomes, and there is a global consensus around the urgency of action [14]. Despite this, the issue of improving health by addressing the SDH continues to have difficulty in reaching policy agendas [15,16]. Policymaking for the SDH is associated with issues such as the complexity of causation linking the SDH to health

outcomes, problems of inter-sectoral collaboration, and the dominance of other priorities, such as healthcare service provision, in the health policy arena [15,17,18]. This has led to an increased interest by public health researchers in political science methods to understand the policy process itself [16,19]. Homelessness, in contrast to relative policy inaction in the SDH field more broadly, has had some success in reaching policy agendas over the last 15 years, with permanent supported housing (PSH) innovations such as *Housing First* and *Common Ground* gaining traction internationally [20,21]. Understanding the policy processes by which this has happened may hold insight for continuing policy work to address homelessness, as well as providing insights for policy action on other SDH.

Homelessness remains a persistent issue in high income countries, with approximately 400,000 people in the European Union and 600,000 in the United States (US) estimated to be experiencing homelessness on any one night [5]. The concept of “home” is broad, extending beyond physical shelter to being a place of security and belonging, central to social and cultural engagement [22]. The definition of homelessness encompasses a spectrum from literal “rooflessness”, where individuals are sleeping rough, to housing precarity, where people are living in inadequate, overcrowded or temporary accommodation [23]. Policy responses to homelessness may focus on a part or on all of this spectrum. The theorised causal

* Corresponding author.

E-mail address: brendan.clifford@sydney.edu.au (B. Clifford).

pathways of homelessness tend to emphasise either structural elements, such as housing supply and the availability of employment [24,25], or individual agency, expressing causes in terms of individual pathology such as substance use disorders or mental illness [26]. Accordingly, policy responses may favour addressing upstream structural determinants (housing supply, employment security), or focus on behavioural interventions which seek to make individuals at risk of or experiencing homelessness “housing ready”. A third more complex approach to homelessness causation has emerged that encompasses both structural and individual explanations, describing individuals who are predisposed to experiencing homelessness because of characteristics which make them vulnerable to structural elements [27–29]. Recent policy responses in the form of PSH approaches attempt to address both individual level and structural elements by providing housing as well as “wrap-around” behavioural interventions [30].

A key question for health actors seeking to address homelessness is understanding their role in a policy field consisting of multiple stakeholders with differing priorities, processes and values. This is especially important given biomedical individualist framings have been previously noted to skew health policy responses towards healthcare service provision rather than social reform, treating the effects rather than the causes of health inequity [31,32]. Nonetheless, people experiencing homelessness require significant resources from the health service, and as health actors become increasingly involved in homelessness service planning, it is necessary to examine the effect of health sector involvement in intersectoral policymaking.

The application of policy process theories (PPT) from political science can provide useful insights into the “black box” of policymaking. With growing recognition of the importance of public policy to health outcomes, interest in applying PPT to health policy has increased, with examples in the areas of health promotion [33], land planning legislation [34], food policy [35], and obesity prevention [36]. Rationalist models of policymaking (such as the policy cycle) describe the use of evidence in a linear way, with policy problems identified, evidence sought, the best solution identified and then implemented and evaluated [37]. Such linear models are criticised for failing to take into account the complex ways in which different actors, institutions, ideologies and political constraints influence and shape the decision-making process [38]. More sophisticated theories attempt to include this complexity in their descriptions of the policy process. Sabatier and Weible give an overview of current theories used to understand the policy process [39], with an understanding of a theory as “a range of approaches that specify the scope of inquiry, lay out assumptions, provide a shared vocabulary among members of a research team, and clearly define and relate concepts in the form of principles and testable hypotheses and propositions” (pg. 3). In addition to meeting this definition for being a theory, the PPT included by Sabatier and Weible are also required to aim at explaining a sizeable part of the policy process, as well as requiring recent theoretical development and empirical application. A brief overview of the theories fulfilling these criteria for Sabatier and Weible are given in Table 1. This study sought to examine the extent of PPT use in homelessness policy study, and in particular the issue of intersectoral working for health actors.

2. Methods

Scholarly literature was searched using a systematised method, adapting previous reviews investigating the application of PPT in public health policy [33,35,36]. Peer reviewed articles were searched for in PubMed, Scopus, CINAHL, SocAbs and PsychINFO databases using the keywords “homeless” or “homelessness” and

“policy”. Broad search terms were used, given the heterogeneity of disciplines which investigate the topic of homelessness. No specific definition of homelessness was used, rather any policy purporting to address homelessness was included given the lack of a standard international classification. Articles published between January 1986 and November 2018 were included. The start year was chosen as the year of the Ottawa Charter [40] given its emphasis on building health public policy. Articles were included if they reported at the supra-national (e.g. European Union), national, state or local government level on issues related to homelessness and the policy change process. Opinion pieces, commentaries, letters and books reviews were excluded, as were organisational policies related to a specific setting (e.g. hospital or clinic-based services) or clinical issue (e.g. tuberculosis or HIV). Only high-income countries, as defined by the World Bank in November 2016, were included [41]. Articles were initially screened by their title and abstract. Those remaining had their full-text examined to identify scholarly articles on homelessness policy change. These articles were then further screened to identify whether a PPT as defined by Sabatier and Weible [39] had been applied (Table 1). An initial search was conducted in November 2016 and a supplemental search using identical search terms was performed in November 2018. The first author (BC) undertook a narrative synthesis of the studies abstracted, and analysed the articles to answer two key questions of relevance to health actors seeking to understand homelessness policy change:

- 1 What issues were identified as being pertinent to homelessness reaching policy agenda?
- 2 What issues were identified relating to the role of health when working intersectorally to address homelessness?

3. Findings

3.1. Use of PPT

The initial search identified 2538 unique records and the supplemental search a further 1742 articles. After screening (Fig. 1), a total of six articles using a formal PPT to examine homelessness policy were identified (Table 2). The year of publication ranged from 1989 to 2018, with two studies based in the United States (US) [42,43], two in Canada [44,45], one in Australia [46] and one in France [47]. Two articles reported use of an adapted PPT [45,47]. Despite a large proportion of the broader literature on homelessness originating in the United Kingdom and Nordic countries, there were no examples of the application of PPT found for these jurisdictions.

3.2. Narrative synthesis

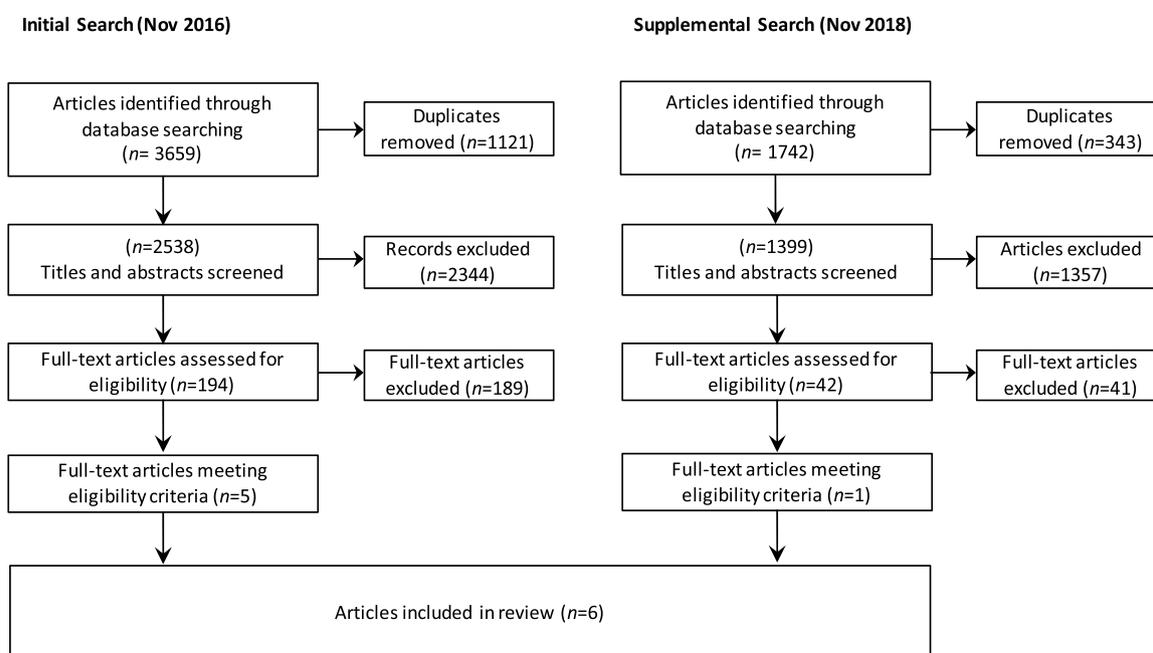
For the narrative synthesis, the key elements of each study were described in terms of the actors involved, policy framings that were used and precipitating events. They are presented here grouped by jurisdiction.

3.2.1. United States

Arnold [42] presents an early example of the application of a PPT to the issue of homelessness, focussing on the passing of federal homelessness legislation during the Reagan Administration of the 1980s. MSA is used to highlight the role of “policy entrepreneurs” – politicians who expend time and effort on bringing homelessness to the federal legislative agenda because of a commitment to social justice. These policy entrepreneurs were successful at passing legislation to establish federal funding for homelessness programs, namely the Emergency Food and Shelter National Board Program, 1983, and the Housing Act of 1986. This was despite a

Table 1
Theoretical Approaches to Policy Process Research [39].

Theory & theorist(s)	Features
Advocacy Coalition Framework (ACF) <i>Sabatier</i> Multiple Streams Approach (MSA) <i>Kingdon</i>	Describes policy-making as arising from policy subsystems where coalitions of actors with shared beliefs engage in strategies to affect decisions by government authorities. Describes policy-making occurring during policy windows, when problem, political and policy streams intersect, due to the action of policy entrepreneurs and/or focussing events.
Punctuated Equilibrium Theory (PET) <i>Baumgartner & Jones</i> Institutional Analysis & Development Framework <i>Ostrom</i> Narrative Policy Framework <i>McBeth, Jones & Shanahan</i>	Describes policy-making as long periods of stasis with static policy communities, with punctuations of rapid change where new actors may join the policy community. Describes policy-making as the management of common pooled resources through the establishment of institutional arrangements (rules) to solve collective action problems and provide shared benefits. Describes policy-making as competing narrative strategies undertaken by actors. The four main narrative elements (setting, characters, plot and moral) play a central role in how individuals process information, communicate and reason.
Policy Feedback Theory <i>Pierson</i> Social Construction & Policy Design <i>Schneider, Ingram & de Leon</i>	Describes policy-making as being shaped by existing policies affecting the meaning of citizenship, forms of governance, the power of groups and the political agenda. Describes policy-making dependent on the social construction and power of socially constructed target groups, with benefits accruing to advantaged groups, and punishments to deviant groups.

**Fig. 1.** Literature search.

lack of support from the Reagan Administration and an indifferent federal bureaucracy who “did not want to pursue something as grand-scale” (pg. 56) as the legislation the policy entrepreneurs proposed [42]. Arnold presents the social justice motivations of these entrepreneurs as being unaccounted for by prior political science theories, which characterises policy processes as a market exchange between interest groups and self-interested legislators. The health sector played little role in the policy process, as the National Mental Health Association, though supportive, paid little attention to it because of interests in other legislation [42].

Both ACF and PET are used by Beard [43] to examine the history of federal policy responses to homelessness in the US. Two “punctuations”, or periods of policy departure, are identified: the economic programs of President Franklin D. Roosevelt’s *New Deal* of the 1930s; and the Reagan Administration of the 1980s. The *New Deal* is mapped against the background of the destabilising force of the Great Depression. *New Deal* policy responses to homelessness

attempt to address macro-structural determinants such as limited job opportunities and lack of appropriate housing, in the form of investment by government in public housing. Health is not seen to play a role in this punctuation, and federal homelessness policy remained focussed on macro-structural factors until the 1980s. The welfare retrenchment of the Reagan Administration marks a new punctuation, where advocacy coalitions at the state level act to change policy imagery. State and city authorities with differing responsibilities employ individual or structural level explanations to shift the responsibility (and the attendant cost) of addressing the issue from one to the other. In New York, for example, city authorities attempt to frame increasing homelessness as resulting from state policies regarding psychiatric deinstitutionalisation. State authorities, conversely, frame homelessness as an individual-level welfare issue, rather than a state-level structural one, emphasising local city-level responses. This reframing of the issue of homelessness from a structural to individual level is mirrored when

Table 2
Summary of articles identified.

Author, year	Study Setting	Policy Level	Theories Used	Features	Role of Health
Arnold, 1989 [42]	United States	National	MSA	Policy entrepreneurs within Senate brought homelessness to agenda due to commitment to social justice.	Minimal role.
Beard, 2013 [43]	United States	National	ACF PET	Federal policy responses to homelessness mapped as long period of stasis with New Deal and Reagan punctuations. Advocacy coalitions work for small, incremental changes between punctuations.	Minimal role.
Parsell, Fitzpatrick, & Busch-Geertsema, 2014 [46]	Australia	National	ACF	Work by policy coalitions led to the implementation of congregate permanent supported housing model (<i>Common Ground</i>), rather than the more evidence-based scatter-site <i>Pathways Housing First</i> models.	Minimal role.
Macnaughton, Nelson, & Goering, 2013	Canada	National	MSA	Policy entrepreneurs identified, and MSA used to portray the success of <i>At Home/Chez Soi</i> as more complex than linear models of evidence translation. Vancouver Olympics identified as focusing event.	Led by national mental health sector.
Fleury et al, 2014	Montreal, Canada	Municipal	ACF	Uses adapted ACF to focus on the role of coalitions in the implementation of <i>At Home/Chez Soi</i> in Montreal.	Conflict between mental health sector and homelessness sector.
Rhenter et al, 2018	Marseilles, France	Municipal/ National	ACF	Uses adapted ACF to define coalitions involved in the setting up and then upscaling of a permanent supported housing program.	Success by local public health/activist coalition at upscaling program. Some resistance to participating in RCT from local actors.

homelessness reaches the federal agenda. Ostensibly worthy initiatives arising from this punctuation, (such as the Emergency Food and Shelter National Board Program, the Housing Act (1986) and the Homeless McKinney Act (1987)), take up this individualist framing of the causes of homeless and emphasizes local-level responses rather than addressing structural determinants. Changes to homeless policy since have been marginal according to Beard [43], though she notes the economic recession of 2008 and efforts (such as *Housing First* programs) to include structural elements may have signalled the beginning of another punctuation.

3.2.2. Canada

Recent homelessness policy developments in Canada are examined by Macnaughton, Nelson and Goering [44] and Fleury et al [45]. Both studies focus on the *At Home/Chez Soi* project, a CAN\$110 million randomised control trial (RCT) involving five cities across Canada, based on *Housing First* principles of rapid rehousing of homeless people with the provision of intensive wrap-around healthcare and social support services. Macnaughton et al [44] use the concepts of policy windows and policy entrepreneurs from Kingdon's MSA in examining the success of the issue of homelessness in reaching policy agendas. The Winter Olympics of 2010 precipitate a policy window for the issue of homelessness (the problem stream) in Vancouver. Former senator Michael Kirby, chair of the Mental Health Commission of Canada (MHCC), is described as a policy entrepreneur who capitalises on this window of policy attention. He joins together the policy, political and problem streams to successfully expand the focus from the city of Vancouver to four other cities across Canada with the funding of the *At Home/Chez Soi* program. The framing of homelessness in terms of mental illness is described as key to achieving consensus for action, driven by the MHCC.

The effect that this central role of health in *At Home/Chez Soi* has on its implementation is explored by Fleury et al [45] using Sabatier's ACF. This is, the authors acknowledge, a novel application of ACF, which is conventionally used over timelines of a decade or greater and seeks to examine policy formulation rather than implementation. Nonetheless, they find that ACF is useful to describe the advocacy coalitions in Montreal which arose after the funding of *At Home/Chez Soi*. While the program was instigated by the mental

health sector, implementation of the program is influenced by two main coalitions: a public mental healthcare coalition, and a homelessness and housing sector coalition. The healthcare coalition has deep core beliefs around individual freedom and the value of clinical science, and favour a top-down, standardised implementation of the *Housing First* model as the basis for evidence based data. The homelessness coalition bases its deep core beliefs on a social obligation to defend the rights of the poor, and has a policy core that emphasises access to subsidised housing. This coalition prioritises the consolidation of existing local resources with the program over program fidelity. This clash of coalitions is ultimately resolved by a third locally based coalition of mediators, actors who cross social service and health sectors assuage the homelessness coalitions concerns sufficiently to achieve sufficient collaboration for implementation.

3.2.3. France

An adapted version of ACF is also applied by Rhenter et al [47] to the setting up of another large scale permanent supported housing randomised trial (*Chez-Soi d'abord*) in France. This is precipitated by the illegal occupation of a building in Marseilles in 2006 by activists to provide accommodation for people with mental illness experiencing homelessness. These activists share a core belief on the political nature of housing as a human right. The legalisation of the squat by municipal authorities brings a coalition of local public health officials with a background in HIV and harm reduction to the project, who share certain core beliefs with the activists (experimentation, social activism, user participation). These public health officials also span the boundary between local activists and the health ministry by translating the original participatory activist project into a research evaluation project with standardised health service usage outcomes, rendering it a policy concern of national bureaucracy and a legitimate recipient of state health funding. The research framing is also credited with giving credibility to an inter-departmental group overseeing the trial, thereby overcoming attempts by Health and Social Security ministries to shift responsibility for implementation from one to the other. Some members of the original activist coalition of the Marseilles project resisted the evaluation framing, due to the loss of the user participation and the privileging of establishing economic viability as the

driver of funding over the principle of housing as a human right. The study describes adapting the ACF to consider the dynamic between the “bottom-up” action of community groups and “top-down” policy experts, regarding the relatively stable policy subsystems of the theory as unsuitable for describing the possibility of the paradigmatic shift necessary to understand social movements.

3.2.4. Australia

Parsell, Fitzpatrick and Busch-Geertsema [46] examine homelessness policy transfer from the US to Australia since the beginning of this century. Sabatier's ACF is used to account for the success of a congregate housing model (*Common Ground*) over other “scatter site” models where people are housed in individual apartments, such as *Housing First*. This is despite a weaker evidence base for the former. Key to the success of *Common Ground* as the model of choice is its uptake by a national alliance of homelessness advocates, and their effectiveness at engaging with business and philanthropy. The alliance is described as sharing a deep core belief regarding the unsatisfactory nature of the *status quo* of homelessness policy, and the need for a new policy response. The deliberate coming together of advocates with a shared deep core belief and their coordination of activities directed to the implementation of *Common Ground* programs are characteristic of Sabatier's advocacy coalitions. Key to its success is the privileging by decision-makers of the experiential, practice-based evidence of *Common Ground* advocates over the more traditional scientific evaluations that underpin scatter site approaches. Policy action in this Australian study is precipitated by homelessness actors rather than the health sector, in contrast to the Canadian and French examples above.

3.3. Homelessness & agenda setting

The articles in the review identify a number of precipitants for homelessness reaching policy agendas: focussing events such as the Olympic Games [44], the normative values of policy entrepreneurs acting out of concern for social justice [42] and the concerted action of stakeholders as advocacy coalitions [46]. Traditional research evidence was not necessary to prompt a policy response [42] and even when available was not necessarily privileged over other forms of evidence [46].

3.4. Homelessness & health

Health intersects with homelessness in these articles as both an actor (the Canadian MHCC, the French Ministry of Health, the American National Mental Health Association) and as an idea or policy framing, expressing homelessness in terms of health effects and/or health service utilisation. In Canada, the implementation of *At Home/Chez Soi* saw tensions arise between health and other actors, with the mental healthcare system emphasising individual clinical outcomes and program fidelity over local homelessness sector priorities [45]. Ultimately the function of the *At Home/Chez Soi* as a trial to produce evidence won out. Tensions between the two sectors were successfully mediated by actors with high legitimacy in both health and housing. This dynamic is repeated in the coalitions described in Marseilles, where a research framework based on health service utilisation is used to garner funding from central government, with the resulting use of randomised control groups encountering resistance from local homelessness actors on ethical grounds. Homelessness was initially expressed as public health problem in Marseilles, in contrast to a narrower definition as a mental health issue in the examples in Canada and New York. The attempt by New York City to frame homelessness as a health issue resulting from psychiatric deinstitutionalisation is notable in that a health framing is used by non-health actors rather than the health sector itself.

4. Discussion

4.1. The use of PPT

This review of the use of political science in homelessness policy found a small number of articles addressing homelessness policy using one of three PPT (MSA, PET, ACF) indicating that political science is underutilised in this field. This limited use of policy theory in this setting reflects the findings of previous reviews of health promotion and nutrition policy [33,35,36], as well as in the SDH more broadly [16]. No single PPT was preferred, supporting the position that PPT are complementary in their ability to highlight particular policy dynamics [48]. The PPT were able to reflect the complexity of homelessness policymaking by accounting for the agency of homelessness policy actors (e.g. legislators, local coalitions, bureaucracies) and differing institutional contexts (e.g. legislative structures, prevailing ideologies) in which policy is produced [37,48]. By articulating policy change as more than a linear translation of evidence into policy, the use of PPT allows other points of consideration for practitioners and researchers seeking to address the issue of homelessness.

The adaptations in the examples by Fleury et al [45] and Rhen-ter et al [47] may represent an evolution in the application of PPT in empirical research, rather than the misuse of policy theory [16]. Embrett and Randall [16] posit that the normative dimension of the SDH (in particular, distributive justice) and the complexity of the SDH make it unappealing to health policy analysts operating in a narrow evidence-based policy paradigm. The adaptation of PPT may thus represent an attempt to better address this normative dimension in the context of the structural disadvantages facing people experiencing homelessness. For instance, the power imbalances between groups with health professional representation compared to those with more local community involvement were presented here using the ACF in the Canadian and French examples, where more dominant biomedical priorities won out [45,47]. While the ACF can elicit the existence of coalitions and their differential access to resources, it does not refer to the potential injustice of such differential access for groups. Addressing this normative aspect of policymaking is a key issue into achieving health equity [17], and presents an important focus for health policy analysis in future research.

4.2. Health & homelessness

The individualised framing of homelessness as a medical issue (and therefore an issue of health service utilisation) is presented as a purposive strategy by actors to push the issue of homelessness on to policy agenda. Evans et al [50] note the *At Home/Chez-Soi* program in Canada rendered homelessness visible as an issue in financial terms in a neoliberal policy environment by articulating it as a problem of health service over-utilisation. In France, proponents of *Chez-Soi d'Abord* focussed on potential economic viability, rather than a human right to housing or the use of knowledge based on lived experience, to gain funding [47]. Reflecting this, the RCT of *Chez-Soi d'Abord* uses health service utilisation as its primary outcome measure, rather than symptom reduction, quality of life or other more person-centred outcomes [51]. In these examples, the problem of homelessness has reached the policy agenda with the orientation of housing as a support for the healthcare system rather than as a sector requiring support from the healthcare system. The framing of homelessness as a health service utilisation issue allows policy responses to bypass more structural social or economic policy reform. This is consistent with trends towards managerialist approaches that convert social issues into problems requiring technical solutions, thereby avoiding more effective structural reform [52,53].

The recent roll-out of PSH programs to address homelessness have been criticised by some for emphasising individual medical treatment to make “housing-ready” citizens, rather than addressing the distribution of housing as a structural determinant of health [54,55]. This echoes Labonté’s concern that social inclusion efforts may focus on adapting people to the needs of the market rather than regulating the market to the needs of the people [56]. This underlines the need to work with broader health promotion frameworks rather than the more narrow disease orientated focus of biomedical approaches to improve the health of people experiencing homelessness [57].

The time period described in US homelessness policy by this review shows the shift from the attempts of the New Deal to address structural causes of homelessness to the more individual framings taken up in the Reagan period [43]. This mirrors the shift in homelessness research in the US during the 1980s described by Jones [49], from a focus on the structural determinants of homelessness to describing rates of substance use and mental illness. This reinforced the framing of homelessness as an issue of individual pathology and highlights the role of evidence-based policy as a method of reinforcing dominant ideologies [20]. There is a need for future research on improving the lives of people experiencing homelessness to counter this shift by including consideration of broader social determinants.

This review highlighted the potential of health framings in raising social issues to policy agendas, reinforcing the need for health actors to advocate on the social determinants of health [58]. There is, however, also a need to be mindful of how medicalising discourses can reinforce social exclusion by supporting individualist framings which then draw focus from more important structural determinants. A greater focus on education on the SDH for health professionals [59], and the provision of equity-oriented healthcare by health services [60] may enable a health system that is both attuned to its role in advocating for social change as well as being aware of the limits of clinical medicine and the importance of non-health sectors to health outcomes.

Intersectoral working is key to addressing the structural causes of health inequity, both in housing and in other social determinants [61]. A stewardship model for health policy, as outlined by Saltman and Ferroussier-Davis [62], emphasises *involvement over control* by the health sector actors when working intersectorally. Initiatives which reflect a stewardship approach include such Health and Wellbeing Boards in the UK, which are led by local government (rather than health authorities) to better facilitate an intersectoral approach to the drivers of health inequity [63]. The impact of such initiatives remains to be seen and ongoing research is required into systems of governance that best facilitate intersectoral collaboration [64].

4.3. Community involvement in policymaking

The examples in this review illustrate the issues that arise involving those with lived experience of homelessness in policy processes, and especially the power imbalances that play out when the priorities of various groups differ. Involving service users in policy making not only enables pragmatic service responses that meet the needs of its target population [65], but also addresses the normative imperative of social inclusion when working with marginalised groups [66]. Governance systems oriented to health equity require mechanisms to meaningfully involve communities in problem definition and solution development [64]. This may be embedded within homelessness programs, such as with the Lived Experience Circles that were part of the Canadian *At Home/Chez-soi* program [67] or by supporting homelessness advocacy organisations in the community, such as Groundswell in the United Kingdom [68] and SAND in Denmark [69]. There are similar efforts

to foster community led policy change on the SDH [70,71], and emerging consumer and community-led research paradigms sensitive to the interplay between evidence and power are of growing importance in this space [72].

4.4. Limitations

This review has a number of limitations. Firstly, it should not be considered a comprehensive overview of homelessness policy analysis, as applications of policy theory outside those meeting the criteria of Sabatier and Weible were not included. Additionally, studies which applied PPT but did not explicitly state their use would not have been identified with our methodology. Only the peer-reviewed literature was searched for articles which applied PPT to homelessness, and so there may be examples in the grey literature that were also not included. The abstraction entailed in the narrative synthesis is subjective, and so it is possible that a different team would have synthesised the studies differently.

5. Conclusion

While this review found a small number of applications of PPT to homelessness, the cases presented provide valuable insights into the working of homelessness policy and the relationship to health. Policy theory accounts for the complexity created by multiple actors, contested causation and competing interests, but may need development to better include the normative dimensions essential to action for health equity. Newer PSH approaches to homelessness may be able to integrate both structural and individual risk factors of homelessness but need to be cognisant of broader market forces. Expressing homelessness as a problem of health service utilisation was seen in this review as an effective strategy to bring homelessness to the policy agenda, but also risked reinforcing the processes of social exclusion by privileging neoliberal evidence-based paradigms over rights-based discourses and the knowledge of local actors. Future policy action on homelessness requires new models of intersectoral governance that account for the complexity of health determinants, a health workforce enabled to engage with the SDH, and meaningful inclusion of those with lived and living experience of homelessness in policy formulation.

Funding

None.

Acknowledgements

AW and PH received funding from the Australian National Health and Medical Research Council. PH also received funding from the Australian Research Council.

References

- [1] Baker E, Beer A, Lester L, Pevalin D, Whitehead C, Bentley R. Is housing a health insult? *International Journal of Environmental Research and Public Health* 2017;14(6):567.
- [2] Shaw M. Housing and public health. *Annual Review of Public Health* 2004;25:397–418.
- [3] Baker E, Lester LH, Bentley R, Beer A. Poor housing quality: prevalence and health effects. *Journal of Prevention & Intervention in the Community* 2016;44(4):219–32.
- [4] Gibson M, Petticrew M, Bamba C, Sowden AJ, Wright KE, Whitehead M. Housing and health inequalities: a synthesis of systematic reviews of interventions aimed at different pathways linking housing and health. *Health & Place* 2011;17(1):175–84.
- [5] Fazel S, Geddes JR, Kushel M. The health of homeless people in high-income countries: descriptive epidemiology, health consequences, and clinical and policy recommendations. *The Lancet* 2014;384(9953):1529–40.

- [6] Ige J, Pilkington P, Orme J, Williams B, Prestwood E, Black D, et al. The relationship between buildings and health: a systematic review. *Journal of Public Health* 2018;41(2):e121–32.
- [7] von dem Knesebeck O, Verde PE, et al. Education and health in 22 European countries. *Social Science & Medicine* 2006;63(5):1344–51.
- [8] Goldman D, Smith JP. The increasing value of education to health. *Social Science & Medicine* 2011;72(10):1728–37.
- [9] Bamba C. Work, worklessness and the political economy of health inequalities. *Journal of Epidemiology and Community Health* (1979-) 2011;65(9):746–50.
- [10] Benach J, Vives A, Amable M, Vanroelen C, Tarafa G, Muntaner C. Precarious employment: understanding an emerging social determinant of health. *Annu Rev Public Health* 2014;35(1):229–53.
- [11] Pathirana TI, Jackson CA. Socioeconomic status and multimorbidity: a systematic review and meta-analysis. *Australian and New Zealand Journal of Public Health* 2018;42(2):186–94.
- [12] Stringhini S, Carmeli C, Jokela M, Avendaño M, Muennig P, Guida F, et al. Socioeconomic status and the 25 x 25 risk factors as determinants of premature mortality: a multicohort study and meta-analysis of 1.7 million men and women. *The Lancet* 2017;389(10075):1229–37.
- [13] Bamba C, Gibson M, Sowden A, Wright K, Whitehead M, Petticrew M. Tackling the wider social determinants of health and health inequalities: evidence from systematic reviews. *Journal of Epidemiology and Community Health* 2010;64(4):284–91.
- [14] CSDH. Closing the gap in a generation: health equity through action on the social determinants of health. Final report of the commission on social determinants of health. Geneva: World Health Organization; 2008.
- [15] Exworthy M. Policy to tackle the social determinants of health: using conceptual models to understand the policy process. *Health Policy and Planning* 2008;23(5):318–27.
- [16] Embrett MG, Randall GE. Social determinants of health and health equity policy research: exploring the use, misuse, and nonuse of policy analysis theory. *Social Science & Medicine* 2014;108(0):147–55.
- [17] Baum FE, Laris P, Fisher M, Newman L, MacDougall C. “Never mind the logic, give me the numbers”: former Australian health ministers’ perspectives on the social determinants of health. *Social Science & Medicine* 2013;87(0):138–46.
- [18] Baker P, Friel S, Kay A, Baum F, Strazdins L, Mackean T. What enables and constrains the inclusion of the social determinants of health inequities in government policy agendas? A narrative review. *International Journal of Health Policy and Management* 2018;7(2):101–11.
- [19] de Leeuw E, Clavier C, Breton E. Health policy—why research it and how: health political science. *Health Research Policy and Systems* 2014;12:55.
- [20] Stanhope V, Dunn K. The curious case of housing first: the limits of evidence based policy. *International Journal of Law and Psychiatry* 2011;34(4):275–82.
- [21] Greenwood RM, Stefancic A, Tsemberis S. Pathways housing first for homeless persons with psychiatric disabilities: program innovation, research, and advocacy. *Journal of Social Issues* 2013;69(4):645–63.
- [22] Chamberlain C, Johnson G, Robinson C. Introduction. In: Chamberlain C, Johnson G, Robinson C, editors. *Homelessness in Australia*. Sydney, NSW: New South Wales Publishing; 2014.
- [23] Amore K, Baker M, Howden-Chapman P. The ETHOS definition and classification of homelessness: an analysis. *European Journal of Homelessness* 2011;5(2).
- [24] Hartman DW. Policy implications from the study of the homeless. *Sociological Practice* 2000;2(2):57–76.
- [25] Martin EJ. Affordable housing, homelessness, and mental health: what health care policy needs to address. *Journal of Health and Human Services Administration* 2015;38(1):67–89.
- [26] Neale J. Homelessness and theory reconsidered. *Housing Studies* 1997;12(1):47–61.
- [27] Pleace N. The new consensus, the old consensus and the provision of services for people sleeping rough. *Housing Studies* 2000;15(4):581–94.
- [28] Fitzpatrick S. Explaining homelessness: a critical realist perspective. *Housing, Theory and Society* 2005;22(1):1–17.
- [29] Frankish CJ, Hwang SW, Quantz D. Homelessness and health in Canada: research lessons and priorities. *Canadian Journal of Public Health* 2005;96(S2):S23–9.
- [30] Baxter AJ, Tweed EJ, Katikireddi SV, Thomson H. Effects of housing first approaches on health and well-being of adults who are homeless or at risk of homelessness: systematic review and meta-analysis of randomised controlled trials. *Journal of Epidemiology and Community Health* 2019, jech-2018-210981.
- [31] Baum F, Delany-Crowe T, MacDougall C, Lawless A, van Eyk H, et al. Ideas, actors and institutions: lessons from South Australian Health in all Policies on what encourages other sectors’ involvement. *BMC Public Health* 2017;17(1):811.
- [32] Lantz PM, Lichtenstein RL, Pollack HA. Health policy approaches to population health: the limits of medicalization. *Health Affairs* 2007;26(5):1253–7.
- [33] Breton E, de Leeuw E. Theories of the policy process in health promotion research: a review. *Health Promotion International* 2011;26(1):82–90.
- [34] Harris P, Kent J, Sainsbury P, Marie-Thow A, Baum F, et al. Creating ‘healthy built environment’ legislation in Australia: a policy analysis. *Health Promotion International* 2018;33(6):1090–100.
- [35] Cullerton K, Donnet T, Lee A, Gallegos D. Using political science to progress public health nutrition: a systematic review. *Public Health Nutrition* 2016;19(11):2070–8.
- [36] Clarke B, Swinburn B, Sacks G. The application of theories of the policy process to obesity prevention: a systematic review and meta-synthesis. *BMC Public Health* 2016;16(1):1084.
- [37] Cairney P. *Understanding public policy*. London: Palgrave Macmillan; 2012.
- [38] Walt G, Shiffman J, Schneider H, Murray SF, Brugha R, Gilson L. ‘Doing’ health policy analysis: methodological and conceptual reflections and challenges. *Health Policy and Planning* 2008;23(5):308–17.
- [39] Sabatier PA, Weible CM. *Theories of the policy process*. New York: Westview Press; 2014.
- [40] WHO. Adopted on 21 November 1986 1986 [Available from: The Ottawa charter for health promotion; 1986 <http://www.euro.who.int/en/publications/policy-documents/ottawa-charter-for-health-promotion>].
- [41] High income countries indicators [Internet]; 2016. Available from: <http://data.worldbank.org/income-level/high-income>.
- [42] Arnold CA. Beyond self-interest: policy entrepreneurs and aid to the homeless. *Policy Studies Journal* 1989;18(1):47–66.
- [43] Beard V. A theoretical understanding of housing and homelessness: federal homelessness and housing policy through the lenses of punctuated equilibrium theory and advocacy coalition frameworks. *Poverty and Public Policy* 2013;5(1):67–87.
- [44] Macnaughton E, Nelson G, Goering P. Bringing politics and evidence together: policy entrepreneurship and the conception of the At Home/Chez Soi Housing First Initiative for addressing homelessness and mental illness in Canada. *Social Science & Medicine* 2013;82:100–7.
- [45] Fleury MJ, Grenier G, Vallée C, Hurtubise R, Lévesque PA. The role of advocacy coalitions in a project implementation process: the example of the planning phase of the At Home/Chez Soi project dealing with homelessness in Montreal. *Evaluation and Program Planning* 2014;45:42–9.
- [46] Parsell C, Fitzpatrick S, Busch-Geertsema V. Common ground in Australia: an object lesson in evidence hierarchies and policy transfer. *Housing Studies* 2014;29(1):69–87.
- [47] Rhenter P, Tinland A, Grard J, Laval C, Mantovani J, Moreau D, et al. Problems maintaining collaborative approaches with excluded populations in a randomised control trial: lessons learned implementing Housing First in France. *Health Research Policy and Systems* 2018;16(1):34.
- [48] Cairney P, Heikkilä T. A comparison of theories of the policy process. In: Sabatier PW, Christopher M, editors. *Theories of the policy process*. New York: Westview Press; 2014. p. 363–90.
- [49] Jones MM. Creating a science of homelessness during the Reagan era. *Milbank Quarterly* 2015;93(1):139–78.
- [50] Evans J, Collins D, Anderson J. Homelessness, bedspace and the case for Housing First in Canada. *Social Science & Medicine* 2016.
- [51] Tinland A, Fortanier C, Girard V, Laval C, Videau B, Rhenter P, et al. Evaluation of the Housing First program in patients with severe mental disorders in France: study protocol for a randomized controlled trial. *Trials* 2013;14(1):309.
- [52] Klíkauer T. What Is Managerialism? *Critical Sociology* 2015;41(7–8):1103–19.
- [53] Germov J. Managerialism in the Australian public health sector: towards the hyper-rationalisation of professional bureaucracies. *Sociology of Health & Illness* 2005;27(6):738–58.
- [54] Willse C. Neo-liberal biopolitics and the invention of chronic homelessness. *Economy and Society* 2010;39(2):155–84.
- [55] Löfstrand CH. Homelessness as an incurable condition? The medicalization of the homeless in the Swedish Special housing provision. In: L’Abate L, editor. *Mental Illnesses - Evaluation, Treatments and Implications*. InTech; 2012. p. 105–26.
- [56] Labonté R. Social inclusion/exclusion: dancing the dialectic. *Health Promotion International* 2004;19(1):115–21.
- [57] Baum F, Newman L, Biedrzycki K, Patterson J. Can a regional government’s social inclusion initiative contribute to the quest for health equity? *Health Promotion International* 2010;25(4):474–82.
- [58] Allen M, Allen J, Hogarth S, Marmot M. *Working for health equity: the role of health professionals*. London: Institute of Health Equity; 2013.
- [59] Metzlj JM, Hansen H. Structural competency: theorizing a new medical engagement with stigma and inequality. *Social Science & Medicine* 2014;103:126–33.
- [60] Ford-Gilboe M, Wathen CN, Varcoe C, Herbert C, Jackson BE, et al. How equity-oriented health care affects health: key mechanisms and implications for primary health care practice and policy. *The Milbank Quarterly* 2018.
- [61] Fisher M, Baum FE, MacDougall C, Newman L, McDermott D. To what extent do Australian health policy documents address social determinants of health and health equity? *Journal of Social Policy* 2016;45(3):545–64.
- [62] Saltman RB, Ferroussier-Davis O. The concept of stewardship in health policy. *Bulletin of the World Health Organization* 2000;78:732–9.
- [63] Humphries R. Health and wellbeing boards: policy and prospects. *Journal of Integrated Care* 2013;21(1):6–12.
- [64] Brown C, Harrison D, Burns H, Ziglio E. *Governance for health equity*. Copenhagen: WHO Regional Office for Europe; 2013.
- [65] Norman T, Pauly B. Including people who experience homelessness: a scoping review of the literature. *The International Journal of Sociology and Social Policy* 2013;33(3/4):136–51.
- [66] Belle-Isle L, Benoit C, Pauly B. Addressing health inequities through social inclusion: the role of community organizations. *Action Research* 2014;12(2):177–93.

- [67] Hatch J. *The Lived Experience Circle: an advisory committee of the At Home/Chez soi project's Winnipeg site*. Winnipeg: Institute of Urban Studies; 2014.
- [68] Fisher M, Milos D, Baum F, Friel S. Social determinants in an Australian urban region: a 'complexity' lens. *Health Promotion International* 2016;31(1):163–74.
- [69] Anker J. Organizing homeless people: exploring the emergence of a user organization in Denmark. *Critical Social Policy* 2008;28(1):27–50.
- [70] Kapilashrami A, Smith KE, Fustukian S, Eltanani MK, Laughlin S, Robertson T, et al. Social movements and public health advocacy in action: the UK people's health movement. *Journal of Public Health* 2016;38(3):413–6.
- [71] Narayan R. The role of the People's Health Movement in putting the social determinants of health on the global agenda. *Health Promotion Journal of Australia* 2006;17(3):186–8.
- [72] Freudenberg N, Tsui E. Evidence, power, and policy change in community-based participatory research. *American Journal of Public Health* 2014;104(1):11–4.