Taking It to the Streets

Homelessness, Health, and Health Care in the United States

Jim, a Korean War veteran in his seventies, lives in a '79 Cadillac. Unable to afford housing, his hygiene is quite poor; access to water is limited to restaurant bathrooms. Jim has severe dental problems, but can't receive assistance from the Veterans Affairs health system because of the labyrinthine rules designed to reduce demand at these inadequately funded facilities.* His health is likely to be severely compromised if he spends the winter months on his cracked leather seat.

Angel is a former day care worker in her fifties who sleeps on downtown streets. She has been assaulted and robbed each week for the past month, but there is no emergency shelter available in her town. With no income, the safety of stable housing is similarly unavailable; meanwhile, her contusions hardly have time to heal.

These vignettes illustrate that homelessness is a health hazard. Homelessness causes health problems: hypothermia or burns from the steam grates that provide warmth; exposure to contagious diseases in crowded emergency shelters—the ground zero for the tuberculosis epidemic of the 1990s; and substance abuse arising from the hopelessness that defines life on the streets. Homelessness exacerbates existing health problems: colds become pneumonia, cuts become infected, and depression becomes psychosis. Finally, homelessness complicates health care: where does a homeless diabetic store insulin and syringes, how can a homeless person with AIDS take the life-saving cocktail of 50 pills, some with food and some with fluids, when no food or fluids are available?

The relation between homelessness and health is clear and compelling. Thus, thousands of committed health care providers are drawn to the 155 federally supported Health Care for the Homeless projects in every state and in Puerto Rico. Each year these projects provide health-related services to 500,000 individuals living on the streets, in abandoned cars, and on the riverbanks of our communities. Health Care for the Homeless services, which generally include outreach, primary medical care, addiction treatment, mental health services, and case management, are frequently the only health services accessible to these individuals.

Yet this program is inadequate, as demonstrated by the two articles in this issue of the *Journal of General Internal Medicine* focusing on the health-related needs and characteristics of our homeless neighbors. Lewis et al.[1] describe barriers to health services faced by women using emergency shelters and feeding programs. O'Toole et al.[2] examine the health-related characteristics of homeless men with veteran status. In each case, the groups described are much sicker than the general population, yet they have limited access to the resources that would improve their health (medical care, housing, an adequate income). Thus do millions of our vulnerable relatives, friends, and neighbors suffer on the streets of the wealthiest nation in the history of the world, even in the shadows of the finest health care institutions ever conceived.

Lewis et al. surveyed a probability sample of nearly 1,000 homeless women in Los Angeles (excluding the most vulnerable: women who literally sleep on the streets and don't access meal programs). Thirty-seven percent of these women reported an unmet need for medical care, as compared to 21% of a national sample of "working" adults.[3] Factors that facilitated obtaining care included receiving treatment for all health care and social problems at the same place (a characteristic of many Health Care for the Homeless clinics), permanent housing, weekend or evening clinic hours, and help finding health care from shelters or soup kitchens.

O'Toole et al. surveyed 425 homeless men in Pittsburgh and Philadelphia. Thirty percent were veterans. Significantly more veterans than nonveterans had a chronic medical condition; a greater percentage of veterans also had two or more mental health conditions. Only 35% of the veterans identified a community clinic that they used for health care, as compared with 67% of nonveterans. Despite the existence of a large Veterans Affairs health system, the tremendous need for health services among homeless veterans persists.

Both studies confirm that the health of individuals living on the streets is precarious. Although the national Health Care for the Homeless program received $130 million in federal funds for fiscal year 2003, these clinics serve perhaps 25% of the two million individuals experiencing homelessness each year. The poor health of these men, women, and children constitutes a significant public health problem across several dimensions. To note only two: homelessness promotes resistant strains of HIV and a renewed prevalence of tuberculosis; uninsured homeless individuals may crowd inner city emergency rooms.

The Health Care for the Homeless movement has made significant contributions toward improving the health of individuals living on the streets. Physicians can support

*"*The Department of Veterans Affairs has had long-standing problems providing care for eligible veterans. Nationwide, there were almost 300,000 veterans in 2002 who were either placed on waiting lists or forced to wait for over six months in order to receive an appointment for necessary care." United States House of Representatives Committee on Government Reform, Minority Staff Special Investigations Division, May 2003, p.4.*

these efforts by: volunteering as providers, board members, or financial supporters with local projects (projects can be located at http://ask.hrsa.gov/pc/); incorporating homeless health issues in research in order to inform practices, programs, and policies; and advocating for public policies that ameliorate homelessness, especially health insurance reforms expanding coverage for indigent individuals. A useful source of information is the National Health Care for the Homeless Council website (http://www.nhchc.org).

Health Care for the Homeless providers are under no illusion that these projects are a sufficient response to the health problems of homeless individuals. The prevalence of homelessness in the United States is between two and five times the rate in Western European countries.[4] It is likely that the universal health insurance systems in these nations, as well as larger public investments in housing, and smaller income disparities, contribute to this difference. Programmatic changes suggested in the Lewis and O'Toole papers, especially the expansion of comprehensive health clinics, could improve the health of individuals living on the streets. Without, however, affordable housing, adequate incomes, and especially comprehensive health insurance, the national tragedy of homelessness—and the extraordinary morbidity and mortality associated with it—will persist.—**Jeff Singer, MSW**, *Health Care for the Homeless, Inc., Baltimore, MD.*

REFERENCES

1. Lewis JH, Andersen RM, Gelberg L. Health care for homeless women: unmet needs and barriers to care. J Gen Intern Med. 2003;18:921–928.
2. O'Toole TP, Conde-Martel A, Gibbon JL, Hanusa BH, Fine MJ. Health care of homeless veterans: why are some individuals falling through the safety net? J Gen Intern Med. 2003;18:929–933.
3. Bloom B, Simpson G, Cohen RA, Parsons PE. Access to Health Care, Part 2: Working-Age Adults. Vital Health Stat. 1997;10:1–47.
4. Toro PA, Tompsett CJ, Schlienz N, Stammel N. Homelessness in the Developed World. A Comparison of Prevalence and Public Opinion across Seven Nations in Europe and North America. Presented at the Fourth European Congress of Community Psychology, Barcelona, Spain, November, 2002.