

Homelessness and Access to Health Care: Policy Options and
Considerations

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Introduction - Background to the Issue

Homelessness is an issue that prevails across most developed countries. In Canada, rates of homelessness are on the rise, and it is not limited to one specific group of people (Currie, Greaves, Golden, & Latimer, 1999, p. 17). Homelessness has many faces: male and female, young and old, lifelong citizens of Canada and immigrants and refugees. There is a clear connection between homelessness and poor health. To understand the health of a population, one needs not only to take into consideration biological or genetic predispositions that make up the group. It is important to consider the many facets of life experience – social experience, economic/income experience – these too have a great impact on the health outcomes of groups and individuals. Of all determinants of health, it is said that income and resulting socio-economic status has had the greatest impact. The evidence is clear when looking at mortality and illness rates by income level: those in the lowest income brackets have the highest rates of illness and disease, resulting in the lowest life expectancy. Falling into this category is the homeless population of Canada.

The living conditions experienced by this group of marginalized people are severe and unsafe. Exposure to extreme weather conditions, unhygienic living areas, and danger of assault are just a few of the day-to-day trials and tribulations undergone by the average homeless person. Often as a result of their living conditions, their experiences of health are much worse than that of the general population. According to the Homelessness Action Plan for Toronto (1999), homeless people are at much higher risk for infectious disease, premature death, acute illness, and chronic health problems... They are also at higher risk for suicide, mental health problems, and drug or alcohol addiction. Their situation is exacerbated by poor nutrition, poor hygiene, and a higher likelihood of experiencing violence or trauma on the street or in a shelter (p. 103).

It is clear to see that negative short and long term health consequences as well as increases in mortality rates are a direct adverse affect of the living conditions of homeless people. And yet, the relationship between homelessness and ill health goes much deeper. Risk factors that may lead to homelessness, are also risk factors for ill health: for example, poverty and substance abuse. Other health conditions, such as mental illness, may act as a risk factor for homelessness, and can be aggravated by the experience of homelessness (Frankish, Hwang, & Quantz, 2005, p. S24).

Now, despite the fact that Canada has universal health care coverage (under which most homeless people are also insured,) this population experiences many barriers to accessing health care services. Under a universal health insurance system, all individuals covered should be provided with care regardless of their monetary status. A research study conducted in Toronto of 1169 homeless individuals however, found that nonfinancial barriers were persistent in keeping many from accessing care. The study found that 17% of the participants responded that they had unmet health care needs – a proportion much higher than that of the general population. This was due to a number of nonfinancial barriers that the researchers identified, including the constant need to secure food and shelter, lack of transportation, and feelings of stigmatization (Hwang, Ueng, Chiu, Kiss, Tolomiczenko, Cowan, Levinson, & Redelmeier, 2010, p. 3). The lack of a permanent address also prevents homeless people from obtaining a health card, which often gets in the way of obtaining medical treatment and making appointments.

As a result of barriers to accessing primary care and follow-up treatments, health care delivery to homeless individuals is largely concentrated in emergency departments (Power,

2008), which becomes a “last resort” for individuals that have unmet health care needs that progressively worsen and become life threatening due to the delay in accessing treatment. This is both ineffective in addressing the long-term health issues of homeless individuals, and costly to the health care system.

Purpose of this Essay

The purpose of this essay is to address the inequality of health experienced by the homeless population. It will outline the need for stronger policy options that will attend to the barriers to health that are being experienced by the homeless. It will go on to list the various policy options, their strengths and weaknesses, and their likelihood of being implemented across Canada. The essay will include statements from the main actors involved in developing any final policies that have an effect on the health of the homeless population. Most importantly, this essay will emphasize the need for action on this issue that will be long-lasting and effective. The homeless population is one that is extremely vulnerable and marginalized; it is one that has seen considerable growth in Canada recently – with many people currently at risk of becoming homeless. With a growing population of homeless individuals in Canada comes a growing need to work towards creating interventions that will reduce homelessness and improve health. This essay will highlight that action cannot only come from those in the health policy sector for results to be lasting – efforts need to come from actors involved in all sectors.

What are the Various Policy Options

The argument stands that the current health care system in place does not effectively address the health care needs of the homeless population (Currie, Greaves, Golden, & Latimer, 1999, p. 103). It assumes that those accessing the system have stable housing and a support system in place, which is in fact the opposite of the reality for homeless individuals. This presents a serious challenge to a health care system that wishes to provide care to all people. The most articulated solutions to the issue of poor health of the homeless population fall under two areas: modified primary care tactics and housing solutions.

The first area of intervention, modified primary care tactics, falls under the umbrella of health policy. It acknowledges the extreme differences between homeless individuals accessing primary care, and non-homeless individuals accessing it. This includes the reality that there are many homeless people, each with a unique burden of illness unlike what is experienced by the general population, and each facing a number of financial and non-financial barriers that prevents them from accessing care. When considering interventions, one has to ask what will be the most effective way to deliver primary care to the homeless population.

For a method to be effective, it needs to address all of the barriers that are likely to be faced. This includes the ability to provide care for those who lack valid provincial health cards. It includes providing care without the need for medications or supplies not covered under provincial health care plans. It includes providing services that can overcome transportation and scheduling challenges that are often faced by homeless individuals who only locate in certain areas. And finally, it includes changing the perceptions of health care providers for them to be more understanding and trustworthy – as many homeless individuals have feelings of stigmatization that can keep them from seeking care (Shortt, Hwang, Stuart, Bedore, Zurba & Darling, 2008)

Short et. al (2008) compiled a collection of primary care models and identified three alternative models that would perform well enough to meet the primary care needs of homeless people. The first model, a “targeted standard facility/clinic site,” was based off of a number of projects in the United States. These clinics have much of the same characteristics as any family physicians office, in which the focus of care is on immediate care for acute illness, screening, and health education. However, in order to meet the unique needs of its homeless patients, they are often located near shelters and have daytime and evening hours of operation. The undertaking of such a model is to help integrate users into the health care system, while providing care that will help to draw away patients from having to resort to the hospital emergency department. The second model, a “fixed outreach site,” is very similar to the previous model in its service focus areas, however it provides care in a setting that is much more accessible to those who would not otherwise reach out for care. Fixed outreach sites are often located within homeless shelters, community drop-in centres, and transitional housing settings. In addition to providing immediate care, a main goal of this type of model is to encourage repeat use of health care services by patients in order to reintegrate them into the system. Such outreach clinics are also linked with other health and social agencies as way of providing further helpful services. The final model, “mobile outreach service,” is perhaps the most accommodating to its homeless patients as it operates from vehicles at sites such as on the street. However, such a model is unable to provide a wide array of services due to lack of space and available equipment. Services include diagnosis, screening, prevention, education, and referrals to other agencies. These services are often lead by nurse practitioner teams.

These models are certainly a giant step towards getting care to those in desperate need of it. By breaking down many of the barriers that homeless people experience in their attempts to access care, it is hoped that those who cannot get off the streets will at least get the treatment that they need. The implementation of such primary care models would take considerable health policy reformation. However, the research indicating the need for such models is plentiful and clear. It is hoped that their effectiveness will be similar to that of the care received by the non-homeless population. In order for this to be achieved there needs to be concrete support for the continuity of care. The Street Health Report (2007) highlights the necessity of continuity: “although emergency departments, walk-in clinics and services geared towards homeless people all provide essential health care services, they are not designed to provide continuity or to address all aspects of a patient’s health care needs” (p. 31). With this in mind, it is important to recognize that simply getting care to the individual is not enough to provide lasting results for their health.

Researchers and other main actors involved in homeless health have cited access to safe housing as the final step necessary to solving most of the health issues of the homeless population. While this solution does not fall under the arena of health policy, it does draw attention to the importance of involving actors from other sectors of public policy in creating long term resolutions to the issue of homelessness and poor health. Providing services that tackle health care needs cannot be discussed in isolation from solutions that work towards getting people off the street. Power (2008) states, “Decent, safe and affordable housing is a basic human necessity. Without it, there is no foundation for people to thrive and enjoy good health, personal security, and stable communities.” The relationship between housing and health acts in two ways: housing affects health, and health affects housing (Hwang, Fuller-Thomson, Hulchanski, Bryant, Habib, Regoeczi, 1999, p. iii). The understanding is that housing has a positive impact on health when the household is safe, clean, and affordable. The housing environment in Canada

has been rather unsupportive to marginalized populations that are at risk of becoming homeless – there is a lack of affordable housing and a growth of insecure employment. This also makes it very difficult to get people who are currently homeless off the street. Bryant (2008) writes that various aspects of this housing crisis have implications for health: “homelessness, the experience of poor living conditions, and the effects of housing insecurity on other social determinants of health.” In order to achieve a housing environment that is supportive to people at risk of returning to, or ending up on the street, changes need to be made at the housing policy level.

Main Actors Involved in Developing Policy

It is clear from the studies that changes in politics, policy and legislation can create a climate that has a positive impact on homelessness. It is these kinds of changes that will have the most substantial and effective effect on the poor health of the homeless population. It can be said that the lack of supportive policy has contributed to putting many people on the street and keeping them there. Those that are currently involved in formulating more progressive policy options come from a wide variety of areas. They are people who work closely with the homeless population and who have a strong understanding of the needs of this group. The authors of the various publications cited in this essay are academics (professors), physicians, and researchers with backgrounds in health, medicine, and public policy. Some are also social workers, nurses, and even currently and previously homeless spokespeople.

Conclusion

All of the above mentioned policy options provide an area of action that has not previously been incited in Canada. They present opportunities for change that will work to target the true needs of the homeless population. Whether they will be adopted strongly depend on the political environment in Canada. While the research and studies that have been conducted provide substantial evidence of the need for such programming, Dunn (2003) highlights the reality of the likelihood that such policies will be passed in Canada: “policy prescriptions that encourage improving social benefits for the poor go against the now well-entrenched retreat of the welfare state.” He also emphasizes the competition between the intervention practices of the various policy sectors. The need for a “direct causal pathway between an intervention and a potential health benefit” is emphasized in his call for more research that highlights the connection between socioeconomic circumstances and health. This will prove to be a difficult task to complete when faced with a housing market that is rife with private sector competition. In order to have government and policy intervention in the creation of more affordable and accessible housing, there will be tremendous barriers to overcome. Nevertheless, the growing inequalities in health experienced by the homeless population are apparent – and so the call for change, new policies, and government investment has been made.

References

- Bryant, T. (2008). Housing and Health: More than Bricks and Mortar. In D. Raphael (Ed.) *Social Determinants of Health Canadian Perspectives 2nd Edition* (235-249). Toronto: Canadian Scholars' Press.
- Currie, W., Greaves, E, Golden, A., Latimer, E. (1999). Report of the Mayor's Homelessness Action Task Force: Taking responsibility for homelessness, an action plan for Toronto . Retrieved from City of Toronto Advisory Committee on Homeless and Socially Isolated Persons website: http://www.toronto.ca/pdf/homeless_action.pdf
- Dunn, J., Hayes, M., Hulchanski, J., Hwang, S., & Potvin, L. (2006). Housing as a socio-economic determinant of health: findings of a national needs, gaps and opportunities assessment. *Canadian Journal of Public Health*, 97(3), S11-5-S12-7. Retrieved from <http://www.ncbi.nlm.nih.gov/pubmed/17357542>
- Hwang, S., Fuller-Thomson, E., Hulchanski, D., Bryant, T., Habib, Y., & Regoeczi, W. (1999). *Housing and Population Health: A Review of the Literature*. Toronto, ON: Centre for Applied Social Research, University of Toronto.
- Hwang, S., Tolomiczenko, G., Kouyoumdjian, F., & Garner, R. (2005). Interventions to Improve the Health of the Homeless: A Systematic Review. *American Journal of Preventive Medicine*, 29(4), 311.e1-311.e9. Retrieved from http://www.homelesshub.ca/ResourceFiles/Systematic_Review_%28AJPM%29.pdf
- Hwang, S., Ueng, J., Chiu, S., Kiss, A., Tolomiczenko, G., Cowan, L., Levinson, W., & Redelmeier, D. (2010). Universal health insurance and health care access for homeless persons. *American Journal of Public Health*, 100(8), 1454-61. Retrieved from

[http://ezproxy.library.yorku.ca/login?url=http://search.proquest.com/docview/650686119
?accountid=15182](http://ezproxy.library.yorku.ca/login?url=http://search.proquest.com/docview/650686119?accountid=15182)

Khandor, E. & Mason, K. (2007) The Street Health Report 2007. Retrieved from Homeless Hub website: <http://www.homelesshub.ca/ResourceFiles/SHReport2007.pdf>

Power, A. (2008). The Homeless Hub: Housing. Retrieved from <http://www.homelesshub.ca/%28S%28v2i3dnrtu3g5tn55bxd3jw45%29%29/Topics/Housing-177.aspx>

Riley, A., Harding, G., Underwood, M., & Carter, Y. (2003). Homelessness: a problem for primary care? *British Journal of General Practice*, 53. 473-479. Retrieved from <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1314623/pdf/12939894.pdf>

Shortt, S. (2006). *Homelessness and Health: A policy synthesis on approaches to delivering primary care for homeless persons*. Kingston, ON: Centre for Health Services and Policy Research, Queen's University.

Shortt, S., Hwang, S., Stuart, H., Bedore, M., Zurba, N., & Darling, M. (2008). Delivering Primary Care to Homeless Persons: A Policy Analysis Approach to Evaluating the Options. *Healthcare Policy*, 4(1), 108-122. Retrieved from <http://www.longwoods.com/content/20012>