Canadian Public Health Association

1997 Position Paper

Homelessness and Health

Preface

The Canadian Public Health Association (CPHA) acknowledges the expertise and time provided by the authors, Dr. Chandrakant P. Shah and Dr. Matthew J. Hodge, from the Department of Preventive Medicine and Biostatistics of the University of Toronto, in the development of this draft position paper.

CPHA also acknowledges the contribution of: the members of the Population Health Committee of the Ontario Medical Association, Dr. Verna Mai, Dr. Lynn Noseworthy, Dr. Noni MacDonald, Ms. Carol Jacobson and Dr. Stephen Hwoang; the Ontario Ministry of Health; the Physicians' Services Incorporated Foundation; and the Laidlaw Foundation.

Executive Summary

Across Canada, homelessness has emerged from shrouded alleyways and steam grates to a position of prominence. Growth in both absolute homelessness, i.e., the complete absence of shelter, and relative homelessness, i.e., shelter in substandard conditions, has occurred in both urban and rural areas. Whether as a cause or a consequence of ill health, homelessness has emerged as a fundamental health issue for Canadians. Substantial evidence of the health consequences, including increased mortality and morbidity and diminished quality of life, is available from both Canadian sources and other jurisdictions.

The causes of homelessness include poverty, changes in the housing market and changing delivery systems for mental health services. As a result, homeless Canadians include increasing numbers of women and children and other groups in special circumstances, including adolescents, persons with mental illness and Aboriginal people.

The recommendations included in this paper, if implemented, will mobilize efforts to ensure that homelessness does not become a permanent feature of Canadian society and that persons at risk for homelessness may benefit from innovative policy and program responses to prevent adverse health consequences.

Recommendations

I. That CPHA, recognizing that homelessness is a health issue, recommend that federal, provincial, territorial and municipal housing authorities, through financial and other incentives, foster a positive policy environment that will encourage the building and maintenance of affordable and appropriate housing.

II. That CPHA encourage Canada Mortgage and Housing Corporation, which intends to survey homeless populations on an ongoing basis, to include questions about the health issues of homeless persons so that health organizations can formulate need-based public

policies.

III. That CPHA, recognizing unemployment and economic instability as causes of homelessness, continue to promote the resolutions it passed at the 1996 CPHA Annual General Meeting with regard to unemployment and health by its continued efforts to build coalitions among health professional groups, national labor organizations and non-government organizations to lobby governments at all levels to develop public policies that will promote meaningful employment for all Canadians and appropriate health, social and income maintenance support services for unemployed persons.

IV. That the CPHA endorse and support the recommendations related to housing in the Report of the Royal Commission on Aboriginal Peoples (1996) (see Appendix I).

V. That CPHA request its provincial and territorial branches and associations to explore with other health organizations and provincial and territorial governments ways and means to address the issue of providing continuity of care and access to ongoing care to persons without health cards or permanent addresses.

VI. That CPHA, with the previously mentioned partners, advocate that provincial and territorial health authorities take steps to ensure that the particular health needs of homeless persons are considered and met as health care services are restructured and reformed.

VII. That CPHA facilitate, on a pilot basis, the development of a Canadian network of persons and organizations concerned about homelessness and health, through Internet means including electronic mail discussion and the World Wide Web, with particular attention to exchanging information on innovative programs to facilitate health services delivery to homeless persons.

VIII. That CPHA request health science faculties to include material in their curricula on the impact of social determinants such as homelessness on health and to cover these topics also during student evaluations.

IX. That CPHA develop a dissemination strategy for this document to include print and electronic media outlets, the Prime Minister's office, provincial and territorial premiers' offices, federal, provincial and territorial ministries of finance, health, community and social services, opposition parties, national Aboriginal groups, and other professional societies and advocacy groups.

X. That CPHA, affirming the position that adequate shelter is a prerequisite for health, endeavour to inform health professionals, non-governmental, street and religious organizations which house and work with homeless people about the extent of homelessness and its links to health with a view to advocacy for affordable, appropriate and available housing.

XI. That CPHA initiate a working group of national professional and health associations, non-governmental, street and religious organizations along with persons who are homeless, to examine the feasibility of a national conference on homelessness and health.

In January 1997, the Canadian Public Health Association Board of Directors approved a discussion paper entitled Health Impacts of Social and Economic Conditions: Implications for Public Policy. This document provides evidence linking the health status of Canadians to broad

social and economic determinants of health and establishes a foundation for policy discussion regarding the health impacts of these determinants.[1]

Building on that foundation, we have developed a position paper on one of those determinants, namely the role of shelter or its absence, that is homelessness, in health. Across Canada, homelessness has emerged from shrouded alleyways and steam grates to a position of prominence. Data from multiple areas indicate that the urban homeless population is not only growing in absolute terms but is also changing in its composition. This growth and diversification has been matched by a reciprocal withering of funds and policies aimed at providing affordable, stable housing. Yet the World Health Organization's definition of health makes clear the important role of adequate shelter in achieving Health for All.

Furthermore, Canada's northern climate makes secure shelter a fundamental prerequisite for health. Despite this, increasing numbers of Canadians are homeless and thus likely to face the particular health problems associated with homelessness. In short, whether as a cause or a consequence of ill health, homelessness has emerged as a fundamental health issue for Canadians.

What is homelessness?

As a prelude to exploring the health consequences of homelessness and the links between homelessness and health, a brief orientation follows. To consider homelessness is to perceive a range of living arrangements and a variety of populations in special circumstances. In 1987, the United Nations (UN), designating the International Year of Shelter for the Homeless, established a distinction between absolute homelessness, i.e., people living on the street and victims of disaster with no homes at all, and relative homelessness, i.e., people housed in dwellings that fail to meet basic standards.[2]

The UN went on to identify five such basic standards. Thus, a dwelling must 1) adequately protect occupants from the elements, 2) be provided with safe water and sanitation, 3) provide for secure tenure and personal safety, 4) lie within easy reach of employment, education, and health care, and 5) be affordable.[2]

Persons living in absolute homelessness are those with no fixed address, including people living on the streets, those using shelters and, in the case of young children, those provided with shelter in conditions bearing little resemblance to a home, often referred to as welfare motels. By contrast, persons living in relative homelessness are generally housed in a dwelling, but one that is sufficiently derelict as to fall short of the UN's five standards.

Closer to home, the federal Library of Parliament's 1994 paper on homelessness[3] describes three categories: chronic, periodic and temporary homelessness. Persons facing chronic homelessness are estimated to make up 20 to 40% of those using emergency shelters and hostels and typically are socially marginal people, often engaged in substance abuse or exhibiting psychiatric conditions.

By contrast, persons facing periodic homelessness generally leave home as a result of a crisis such as domestic violence or abuse, but may return to such homes after periods in shelters or on the streets. The last group, persons facing temporary homelessness, comprises those who lose their shelter because of fire or flood, hospitalization, or increasingly, unemployment leading to eviction or foreclosure.[3]

In Canada, the absolutely homeless are the most visible of those who are homeless, for they are found disproportionately in urban areas. By contrast, relative homelessness, while present in the cities, is most striking in remote areas and particularly in Aboriginal communities.[4 - 6] From a health perspective, this distinction is important, because the health conditions predisposing to homelessness differ for each, as do the health consequences.

Who are the homeless?

The stereotypic homeless person is generally thought to be a single alcoholic or possibly drug-using male, and much of the policy and program response to homelessness reflects this outdated view. Thus, shelters in many urban centres trace their roots to the idea that homelessness was a temporary aberration afflicting men who were “down on their luck”. Furthermore, shelters were thought to be transition places, as people moved among various “housing choices”.[7]

The reality of today's homeless persons is different: more mothers and children are among the homeless; shelters increasingly function as longer-stay housing; and there is a reduced range of housing options for people marginalized from housing markets. In addition, since persons in special circumstances make up an increasing proportion of the homeless, meeting their housing needs requires more of increasingly scarce resources.

Persons with mental illness

These populations in special circumstances include persons with major psychiatric illness for whom the trend to deinstitutionalization has provided at best a patchy infrastructure of care. Since many are so debilitated that they cannot muster the organizational and financial wherewithal to establish and maintain a permanent place of residence, their health renders them at high risk of homelessness. Although it is estimated that only 5 to 7% of homeless persons with mental illness require institutionalization,[8] once they are homeless, the lack of mental health infrastructure, particularly community-based treatment services, leaves them vulnerable to both the morbidity of their predisposing illness and the morbidity attendant on homelessness.

Street youth

Similarly, the growth of so-called “street youth” has created a population of adolescents in special circumstances, over 70% of whom report leaving home because of physical and/or sexual abuse.[9] Their health needs are similar to those of homeless adults, but may also include treatment and prevention of diseases arising from commercial sex work.[10] Of particular importance and often overlooked are the attention and resources necessary for their personal development, including education.

Families with children

Across North America, the most startling demographic change noted among the homeless has been the rapid growth in the numbers of homeless women and children.

In Montreal, it is estimated that in a given year, 30 to 40% of homeless people are women.[11] On an average day in Toronto in November 1995, 3600 people stayed in emergency shelters; 50% were families with children.[12] Analysis of labor market data in the United States suggests that part of this increase may be due to the decline of the economic value of marriage, fueled in part by substantial contraction of job opportunities for semiskilled men.[7] As Canada's economy shifts from primary industry to service-oriented, knowledge-based industry, jobs for relatively unskilled men vanish, and those for women of similar skill or educational levels rarely provide child care or high enough wages to make child care possible.

As a result, more women find themselves and their children trapped in a cycle of low income and a tenuous hold on stable shelter. Welfare motels and hostels are available, resulting in fewer people on the streets, however, studies of children housed in such facilities report increasing frequencies of acute illness, chronic illness and developmental slowing or delay.[13 - 17]

Aboriginal people

An additional population in special circumstances is Aboriginal persons. Whether absolutely homeless on the streets of Canada's cities or housed in squalid, crowded and dilapidated buildings on reserves, Aboriginal persons have particular risk factors for homelessness; efforts to remedy such homelessness require attention to these causes.[18]

Why the growth in homelessness?

Over the last 15 years, much has been written describing and analyzing the growth in homelessness. Precise data on the numbers of homeless persons defy collection, if only because systems for counting citizens at census times generally are based on place of residence. Even in surveys of the homeless, identification of doubled-up persons and of places where homeless people seek shelter outside institutions is notoriously difficult.

Nevertheless, Canadian investigators and advocates have gathered data that, taken together, provide compelling evidence of substantial growth. Thus, one group has estimated that in Toronto 25,000 people were homeless in 1996, double the number in 1994;[19] the Good Shepherd Hostel reports a 30% increase in people using its overnight shelter between 1995 and 1996; and the Metro Children's Aid Society reports a 33% increase in households sharing accommodation and a 52% increase in families in shelters over the same period. Workers on the Anishnawbe Street Patrol in the same city estimate a doubling of the number of persons on the street between 1993 and 1996.[20]

Further west, after reductions in welfare payments in Calgary during the early 1990s, 55% of recipients were reported to be facing eviction. In Montreal, 1994 data indicated that 27,000 people were homeless, 40% of whom were from outside Montreal.[21] This magnet role of larger urban centres is particularly acute with street youth. As an example, Addiction Research Foundation data from 1992 estimated that two-thirds of the 3,00 0- 5,000 homeless youths in Toronto were from outside Metro Toronto.[9]

Although estimating the total number of homeless persons in any jurisdiction is difficult, as long ago as 1986, 130,000 - 250,000 Canadians were estimated to be homeless or living in substandard housing.[3] In 1987, the Canadian Council on Social Development (CCSD) conducted a cross-sectional survey of homeless people by counting all persons staying in shelters on a particular night. On the basis of this sample, the CCSD estimated that 10,672 people stayed in emergency shelters.

Even this snapshot is likely to be a substantial underestimate, as it does not include women or children in emergency shelters for victims of domestic violence or those doubled-up with friends or relatives.[2] In the fall of 1997, the Canada Mortgage and Housing Corporation (CMHC) is planning a national survey and then periodic ongoing surveillance of the homeless population in Canada. It provides an opportunity for public health organizations to lobby CMHC to include in this survey questions related to health issues of the homeless persons.[22]

The growth in the number of homeless persons leads inexorably to the question of "why?". Although perhaps conceptually distinct, causes of homelessness, for individuals are likely to act in concert and multiply. The growth of homelessness appears attributable to three broad categories of factors: a) poverty, b) changes in housing markets, and c) psychiatric morbidity and changes in mental health services.

Poverty and housing market

The first two of these, poverty and housing market conditions, are linked inextricably to shelter, as it is the largest single item expenditure for most Canadians. While a very small number of persons choose to have a homeless life-style, the majority of people are there because of economic fall out. This is illustrated by income data:

15% of 458 homeless persons reported no income during the month before a Toronto survey was done, and only 10% reported receiving more than $1000 during the previous month.[23]

Furthermore, stubbornly high rates of unemployment have increased the tenuousness of many people's shelter, and have contributed to adverse health effects.[24] As a result, poverty rates in Canada have risen over the last decade, particularly among women and children. This is clearly evident in Canada's having 1.4 million children living below the poverty line.[1] To be sure, poverty does not lead inevitably to homelessness, but even if the stock of affordable rental housing is constant, more persons in economically precarious circumstances means more persons at risk for homelessness.

Substantial evidence suggests that the stock of affordable rental housing has contracted, compounding the lower funds paid to poor individuals in the form of social assistance. The gentrification of Canada's cities has led to increasing rents and loss of much of the stock of affordable housing, particularly single room occupancy buildings. Furthermore, this process is not merely a big city phenomenon: between 1984 and 1988, the average rent on a three-bedroom living space increased by 31.3% in Canada's largest city, Toronto, but also by 24.8% in Saint John, New Brunswick. In 1991, the Canada Mortgage and Housing Corporation reported that one in five of Canada's renting households lived in inadequate or unsuitable housing.[20]

For poor households, the search for shelter is made even more difficult by landlord resistance. Survey data suggest that one-third of small-scale landlords and two-thirds of corporate landlords with rental housing affordable to persons receiving social assistance would not rent available units to persons receiving such payments.[20]

Since the focus of this paper is on health issues of the homeless, we will not deal with possible housing solutions. Ward, in his book Organizing for the Homeless, has discussed several solutions involving innovative housing models, including those in which homeless people run or participate in running the housing complexes, such as Dixon Hall-City home Housing Project in Toronto.[25]

Psychiatry, morbidity and changes in mental health services

Aside from poverty and changing housing markets, illness itself, particularly poor mental health, can precipitate homelessness. In much of the writing on homelessness, it is common to find the deinstitutionalization of mental health services cited as a significant cause. Although the number of inpatient beds has been reduced markedly (Vancouver's Riverview Psychiatric Hospital had 1,000 beds in 1993, down from 4,800 in 1960),[26] much of this occurred before the current growth in homelessness.

Nevertheless, deinstitutionalization continues to play a causal role, in that outpatient or ambulatory substitutes for inpatient care and for forced hospitalization remain inadequate to meet demand, particularly in the area of treatment for alcohol and drug use. In addition, becoming homeless, with the attendant loss of affiliation, may well exacerbate the morbidity associated with mental illness.

From the street, the data are not encouraging. Surveys of homeless persons report that from 10 to 90% have some form of mental illness, a range that reflects both definitional uncertainty and the over-representation of mental illness among homeless persons.[27] In some cases, illness predisposes to homelessness, while in others, homelessness itself precipitates mental illness, notably alcohol and drug abuse. Thus, in a longitudinal study of 1,399 homeless adults in California, it was reported that while 45.6% had no medical or psychiatric illness upon becoming homeless, 9.3% of these became excessive users of alcohol, 4.4% became users of illegal drugs and 0.9% were hospitalized in a psychiatric facility within 12 months.[28] Since the 1980s, crack/cocaine addiction has become a major contributing factor in the growth of homelessness in the United States. Although its impact in Canada is less well documented, this addiction is emerging as one of the causes of homelessness.

A 1992 survey of Ottawa street youth noted that 92% had attempted suicide. Addiction Research Foundation data from Toronto reported that drug use was 14 times higher among street youth than among students who had never run away from home,[9] and that nearly 90% of street youth reported either an alcohol or a drug problem.[29] In Canada, among 160 persons using shelters or drop-in services in Hamilton, 36% had some form of mental illness; among those over age 65, this soared to 66%.[30]

For homeless women, substance abuse exacts a lesser toll than for men. However, major psychiatric disorders such as schizophrenia appear to be more severe among women.[31] A study in St. Louis reported that 33.8% of women had post-traumatic stress disorder, compared with 3.2% of low-income housed women and 1.3% of other women.[32]

Housing issues in Aboriginal communities

Before turning more explicitly to health issues, a word about Canada's Aboriginal people is in order. All three previously identified contributory causes may come together with particular force when they occur in remote communities. Moreover, among off-reserve Aboriginal people, housing has been cited as the most important unmet need. On and off reserves, relative homelessness has been well-documented by both government and other sources, including the Royal Commission on Aboriginal Peoples.[6]

- Houses occupied by Aboriginal people are twice as likely to need major repairs as are those of all Canadians.
- Aboriginal households are more than 90 times as likely as other Canadian households to be living without a piped water supply. On reserves, 14% of all dwellings have no indoor plumbing, 12.5% have no central heating and 6.5% have no electricity.

Relative homelessness with attendant poor sanitation and crowding is likely to increase the risks of communicable disease transmission and, in cases of house fires, to exact a higher injury toll.

Recommendations

I. That CPHA, recognizing that homelessness is a health issue, recommend that federal, provincial, territorial and municipal housing authorities, through financial and other incentives, foster a positive policy environment that will encourage the building and maintenance of affordable and appropriate housing.

II. That CPHA encourage Canada Mortgage and Housing Corporation, which intends to survey homeless populations on an ongoing basis, to include questions about the health issues of homeless persons so that health organizations can formulate need-based public policies.

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IV. That the CPHA endorse and support the recommendations related to housing in the Report of the Royal Commission on Aboriginal Peoples (1996) (see Appendix I).

Linking homelessness and health

If homelessness were only a matter of some people lacking shelter and of some living in substandard shelter, health workers and advocates might well consider homelessness to be merely a social concern. The reality of homelessness in Canada, however, is intimately linked to health status, in that ill health predisposes to homelessness, and adverse health effects and particular health needs follow on from homelessness.

Central to the links between health and homelessness is the notion of equity. The WHO has explicitly recognized the role of shelter in its definition of health, and Canada has ratified several international conventions making reference to links between health and shelter, including the United Nations Convention on the Rights of the Child.

On the street, homelessness leads to increased rates of illness, accentuated by the difficulties of providing health care services to homeless persons. The deaths by freezing of three homeless people in Toronto in January 1996, and a recent death at the time of writing (January 1997) are a reminder of increased age-adjusted mortality rates among homeless persons.[33] Of 202 deaths among homeless people in Toronto between 1979 and 1990, 71% of the dead were under the age of 70, compared with 38% of deaths in people of that age among the housed population. As a group, homeless persons are substantially younger than are the members of the general population; the excess of deaths arises mainly from deaths due to injury and from the sequelae of substance abuse, particularly suicide from overdose and alcoholic liver disease.[34]

Tuberculosis

Far more burdensome are the non-fatal illnesses associated with homelessness. Much has been written about tuberculosis (TB) among homeless people in US cities, yet the disease appears to be emerging as a substantial public health issue in Canadian cities as well. Tuberculosis infection is highly transmissible, because the mycobacterium that causes it is spread through the air.

Historically, the public health emphasis on sanitation and improved housing and living conditions coincided with marked reductions in the death rates from TB. As homelessness has risen in the United States, increases of epidemic proportions have been noted in TB infections among homeless people.[35] These increases have been compounded by the spread of HIV (HIV renders infected individuals more susceptible to TB infection) and by increased resistance due to partial treatment.

Treatment for TB infection generally requires multiple agents for a period of several months. Partial treatment arises when infected individuals take medication for less than the prescribed duration, and it tends to result in organisms that are resistant to the medication rather than in eradication of all organisms.

Persons without shelter are at particular risk for partial treatment, since their lives are sufficiently chaotic that remembering to take pills daily for several months becomes an insurmountable challenge. Furthermore, despite the free provision of anti-TB medication in many jurisdictions, a homeless person may well have no safe, secure place in which to store the medications.

The epidemic of TB occurring during the late 1980s and early 1990s led to programs of directly observed treatment (DOT), providing daily supervised administration of anti-TB medications.[36] DOT represents an effective, albeit resource-intensive, response to the synergy between homelessness as a risk factor for both TB infection and for partial treatment.

The US epidemic began almost 10 years ago, but there is some evidence of a similar process under way among Canada's homeless. A survey of TB skin test positivity among homeless people in Toronto reported that 48% had positive skin tests, results that would ideally lead to a six-month course of treatment.[37]

HIV and AIDS

In San Francisco, HIV has been reported to be more prevalent among homeless persons than among the housed;[38] should people with HIV infection face substantial downward drift in economic terms, this is likely to become an infection associated with homelessness.

Musculoskeletal diseases

Although infectious diseases draw the attention of classic public health concern, musculoskeletal conditions exact a heavy toll among homeless adults who spend much of their day outdoors and often on their feet. Thus, homeless persons in Toronto report a 220% higher prevalence of arthritis than do housed persons.[23] A survey among 124 homeless persons in Vancouver noted that 52% reported a current health problem and 58% had a current dental problem requiring the attention of a dentist.[26] In addition, homeless persons face an annual incidence of assault approaching 40%, and among women, annual risks of sexual assault are approximately 20%. In the year before these data were gathered, 11.4% of respondents reported being hit by motor vehicles and 8.5% reported frostbite. Population survey data indicate that 2% of people in Toronto reported a traffic-related injury during the same period.[23]

Health issues of street youths

Sexually transmitted diseases and mental health concerns dominate the health needs of street youth. An Edmonton survey of street youth and juvenile sex workers reported positive culture rates of 49% for Neisseria gonorrhoeae and 83% for Chlamydia trachomatis. Furthermore, no contraception was used by 57% of those engaged in sex work and by 85% of street youth.[39]

Despite similar data in Toronto, 52% of a sample of youth engaged in sex work felt that their risk of HIV infection was the same or less than that of other youth.[40]

On issues of mental health, homeless youth are noted to have substantially higher morbidity than their housed counterparts. Data from a study of Toronto street youth show that 37% of males had a history of attempted suicide, in contrast to 61% of females, that 83% had used cannabis during the previous year and 31% had used cocaine, that 28% injected drugs at some point and that 4% had shared needles within the previous year. In addition, about half reported evidence of depression at some point during the three months preceding the interview, and 46% of females reported some form of sexual abuse.[9]

Health issues of children living with homeless parents

Compared with children who have permanent homes, homeless children face particular health risks, including obesity, anemia, injuries and burns and developmental delay. To date, relatively few Canadian data are available on the health of homeless children, but results from other jurisdictions herald substantial morbidity among homeless children. Thus, obesity is approximately six times more prevalent among homeless children in Washington state.[14] Among 256 homeless children in New York City attending a primary care clinic, higher levels of serum lead were noted in comparison with levels in housed children of similar socioeconomic status.

Similarly, in 11% of a random sample of homeless children in Philadelphia, lead poisoning had been diagnosed during the previous year.[15] In addition to the cognitive effects of lead, high serum levels may compound or exacerbate anemia, which is itself more common among homeless children.[16] This higher rate of anemia may be due partly to dietary deficiency: children living in shelters in Kansas City were noted to be receiving less than 50% of the recommended daily allowance of iron and folic acid.[17]

Perhaps of most concern from a long-term perspective is the evidence of developmental delay among homeless children. Data on the mothers of homeless children consistently report low educational attainment. Evidence of developmental delay among these children suggests that substantial efforts are needed to reverse a cycle linking minimal employment skills and homelessness.

Of 151 children living in Massachusetts shelters, roughly half had developmental lags as measured by the Denver Developmental Screening Test.[13] Among Philadelphia homeless children, measures of preschool children's visual motor skills and expressive vocabulary both yielded results substantially below the population mean, and only one-third of school-age children were reading at the appropriate age level. Half of the children in the sample were reported to have missed 5 or more days of school during the preceding two months, and 30% missed 10 or more days.[15]

Paralleling the higher risk of injuries seen among homeless adults, homeless children appear to be at higher risk of injuries and burns. Again in the Philadelphia sample, 14% had been burned sufficiently to produce a scar, and 8% had been hospitalized because of injury during the previous year.[15] In short, the foundations for the homelessness of the next century are being laid among the children of today.[41]

Health issues of Aboriginal peoples

As a result of relative homelessness, the incidence rates of tuberculosis, otitis media, upper and lower respiratory tract infections, pneumonia, gastrointestinal diseases, skin infection, cancer due

to second-hand smoking and deaths due to fire are two to seven times greater in Aboriginal populations than in the rest of the Canadian population.[4, 6]

Addressing health service needs of homeless persons

Housed people certainly face all of these health risks, in varying magnitude, but homelessness makes the provision and use of health services rather different. Thus, in all Canadian provinces, health care is available free of charge to persons who present valid provincial medical insurance cards, yet application for the card requires an address to which it can be sent.

The issue of care refused or limited because of lack of a health card has arisen repeatedly among surveys of homeless persons and surveys of those providing insured health services.[20, 23] In an era of management information systems, denying care to persons in generally poor health seems wrong-headed, to say nothing of short-sighted. Preventive efforts, particularly with respect to health conditions such as hypertension, HIV infection and skin care, may well reduce the need for acute “catch-up” care among homeless persons.[42, 43]

In addition, although high proportions of Canadian homeless persons report seeing a physician, many of these visits are related to the completion of forms required by social services agencies.[19] Ongoing relationships with primary care practitioners are likely to be rare among homeless people who move often and may be ill-equipped to keep or remember appointments. Traditionally, emergency rooms have provided primary care to homeless persons, but the growth of homelessness and its concentration in urban core areas leaves the burden of this care to be borne by a few institutions in each of Canada's major cities. Staff burnout and fatigue are common, as is an apparent obliviousness to certain issues, particularly home care after discharge for persons who have no homes as well as compliance of these persons with prescribed medication routines.[44, 45]

Given the multiple health problems of homeless persons are often compounded by substance abuse and psychiatric illness, particular attention is needed to establish delivery systems that can provide care to persons with no fixed address and often minimal social supports. Innovation in this regard, particularly for homeless persons with psychiatric illness, has focused on case management. While there is program-to-program variation, the central idea behind case management is a one-stop contact with health care systems and often social services. Successful programs report improved continuity of care, reduced use of emergency room facilities and, in some cases, decreased readmission rates.[46 - 49]

At the point of care delivery, homeless persons have raised concerns about the insensitivity of care providers.[23] Long-term attitudinal change is an important goal for health care professionals, but a short-term program providing compassionate care may alleviate some of these concerns. A randomized, controlled trial carried out at Toronto's Wellesley Hospital reported lower rates of return visits among persons with no fixed address who had been approached by a volunteer and offered a chance to talk and to be heard, as compared with similar persons who had received regular care. This suggests that client satisfaction may be an important part of cost-effective care delivery.[50]

The growth of homelessness has prompted a burst of new programs and interventions, including street patrols, cold weather alert systems and novel approaches to service delivery, such as mobile health vans. Many of these are sufficiently recent that little information on effectiveness is

available. Nevertheless, evaluation and ongoing innovation are vital to meeting the health needs of homeless persons.

Recommendations

V. That CPHA request its provincial and territorial branches and associations to explore with other health organizations and provincial and territorial governments ways and means to address the issue of providing continuity of care and access to ongoing care to persons without health cards or permanent addresses.

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VIII. That CPHA request health science faculties to include material in their curricula on the impact of social determinants such as homelessness on health and to cover these topics also during student evaluations.

Conclusion

Canadians are justifiably proud of universally accessible health services. As greater attention is paid to the social determinants of health and broader conceptions of health and health care, addressing homelessness is essential if all Canadians are to have the opportunity to live healthy, productive lives. Although it is increasingly fashionable to speak of individual responsibility and welfare reform of various stripes, central to the notion of Canada's civil society should be affordable, secure shelter. The time is ripe for the CPHA membership to build a critical mass of advocacy and action to ensure that no one is left out in the cold.

Recommendations

IX. That CPHA develop a dissemination strategy for this document to include print and electronic media outlets, the Prime Minister's office, provincial and territorial premiers' offices, federal, provincial and territorial ministries of finance, health, community and social services, opposition parties, national Aboriginal groups, and other professional societies and advocacy groups.

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examine the feasibility of a national conference on homelessness and health.

References

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Appendix I Report of the Royal Commission on Aboriginal Peoples Volume 5. Appendix A, Summary Recommendations Canada Communication Group, Ottawa, 1996. (pp. 216-219)

Commitment to Adequate Housing

3.4.1 Federal and provincial governments address Aboriginal housing and community services on the basis of the following policy principles:

a. Governments have an obligation to ensure that Aboriginal people have adequate shelter, water and sanitation services.
b. Governments have a responsibility to restore an economic base to Aboriginal people that enables them to meet their needs.
c. Aboriginal people, individually and collectively, are responsible for meeting their housing needs according to their ability to pay or contribute in kind.
d. Governments must supplement the resources available to Aboriginal people so that their housing needs are fully met.
e. Aboriginal nations should assume authority over all housing matters as a core area of self-government jurisdiction.
f. Acute risks to health and safety should be treated as an emergency and targeted for immediate action.

3.4.2 The government of Canada clarify with treaty nations a modern understanding of existing treaty terms regarding housing.

3.4.3 The government of Canada make resources available over the next 10 years to ensure that housing for Aboriginal people on-reserve is fully adequate in quantity and quality and engage the governments of the provinces and territories to reach the same goal in rural and northern communities and in urban areas.

Water and Sewage Systems

3.4.4 The government of Canada provide additional resources for construction, upgrading and operation of water and sewage systems to ensure that adequate facilities and operating systems are in place in all First Nations communities within five years.

3.4.5 The government of Canada provide funding and technical support to First Nations governments to operate and maintain community water and sewer systems and to establish technical support institutions as required

Housing in First Nations Communities

3.4.6 The government of Canada and First Nations governments and people undertake to meet the need of First Nations people for adequate housing within 10 years.

3.4.7 The government of Canada complement the resources supplied by First Nations people in a two-to-one ratio or as necessary to achieve adequate housing in 10 years by

- providing capital subsidies and committing to loan subsidies for construction of new homes and renovations:

- providing funds for property insurance and regular maintenance for home occupants receiving social assistance or with low earned incomes;
- paying rental subsidies for those receiving social assistance or with low earned incomes in amounts that are equitable compared to off-reserve programs; and
- offering financial incentives for private home ownership.

3.4.8 First Nations governments and people make every effort to marshall more resources for housing and community services, through financial contributions from residents in the form of maintenance fees, rents or mortgage payments, and contributions in kind, such as sweat equity and local materials.

3.4.9 First Nations governments assume jurisdiction over housing at the earliest opportunity, enact clear laws regarding housing tenure, and pursue authority to adjust other programs such as social assistance with a view to marshalling more resources for housing.

3.4.10 First Nations governments develop institutions at the nation level or through inter-nation agreements to administer housing and tenure regimes and deliver housing programs with financial and technical support from the government of Canada.

3.4.11 The government of Canada support the efforts of First Nations communities to develop and implement their own tenure systems and housing programs, innovative uses of social assistance to stimulate contributions to housing, and institutions above the community level.

Housing in Non-Reserve Communities

3.4.12 The government of Canada and the governments of the provinces and territories undertake to meet fully, in cooperation with Aboriginal people and within 10 years, the need for adequate housing of Aboriginal people not living on reserves.

3.4.13 Aboriginal people not living on reserves make every effort to marshall more resources for housing in a variety of ways, through contributions in kind, sue of local materials, and effective housing organizations.

3.4.14 The government of Canada engage the provincial and territorial governments in a strategy to meet the housing needs of Aboriginal people living in non-reserve communities by reinstating and increasing funding for new social housing and mortgage subsidies under the Aboriginal off-reserve programs of the Canada Mortgage and Housing Corporation (CMHC);

- providing greater autonomy and flexibility to Aboriginal organizations
- delivering the program in rural areas and to urban social housing corporations; and
- providing rental subsidies as a cost-effective option where rental markets exist.

Economic Development

3.4.15 The government of Canada help Aboriginal people exploit the economic development opportunities arising from an increase in construction, repair and maintenance of dwellings for Aboriginal people

- by providing funding and support through training and business development programs; and
- by actively expanding the involvement of Aboriginal financial institutions in mortgage financing as agents of CMHC and as mortgage lenders.