Homelessness and Health

Moving Beyond Health Care

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"On my honor, I have neither given nor received any unacknowledged aid on this paper."
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The impetus for this paper stems from my personal experience interning at the So Others Might Eat (SOME) Medical Clinic in Washington, D.C. during the summer of 2008. The clinic where I worked is just one component of a multi-faceted organization whose mission is to serve and empower the homeless of the nation's capital. Given my origins in a small community in South East Texas, both the environment and the population were completely foreign to me. Thus, the summer was filled with a multitude of eye-opening experiences. While I enjoyed and learned from the various duties that I performed there, there is no question that the most beneficial portion of my summer came from interacting with the unique population whom I served.

My primary task at the clinic was triaging patients, so after only a few days of work I had a sense of the pervasive nature of the health problems faced by this population. Nearly every patient we saw suffered from multiple, serious health problems such as diabetes, hypertension, Hepatitis C, HIV, various vision problems, and other effects of years of substance abuse. While this alone was disconcerting, I soon discovered that their official diagnoses were only the beginning. After a few weeks in the clinic, I had become much more comfortable with my new surroundings and had begun to establish relationships with some of the patients. At this point, as I began to hear personal accounts of the struggles associated with daily life on the street, I realized the extensive and deeply-rooted nature of this population's problems. For the first time, I saw clearly the indirect influence that nearly every aspect of one's life may have on one's health as well as the intricate interconnections that exist between these domains.

Most striking, however, was the revelation that many of these individuals were born into situations that nearly predestined them for this fate. For instance, one young girl was born to a crack-addicted, homeless mother who taught her to use crack and other illicit drugs when she was only eight years old. It is not difficult to imagine how this child may have a difficult time functioning as a member of mainstream society an adult. In stark contrast, my own childhood was filled with loving parents who

supported my every endeavor fulfilled every need and want I expressed. Knowing that the family into which one is born, which no one earns of her own merit, can dictate such diverse life-courses left me very uncomfortable with the winning hand I had been dealt.

Such disheartening revelations did not monopolize my time spent at SOME, however. In addition to revealing a broader array of problems for the health care sector than I had previously imagined could exist, SOME provided a working model for how these deficiencies could be effectively treated. As I mentioned, the medical clinic was only one component of the organization. SOME seeks to rehabilitate individuals by acknowledging the interaction between the different facets of life and addressing all aspects of their problems. SOME provides emergency services such as a soup kitchen, shower and clothing room, dental and medical clinic, mental health services, and temporary housing. They offer recovery treatment such as a rehabilitation program for those with various addictions and a job-training program. Finally, they offer stability services that include many different forms of affordable and safe housing, ranging from all-male SROs to housing for families. I saw the manifestation of the success of this commitment to caring for the "whole person" right before my eyes. For one, I could see a change in the health and attitude of patients coming through the program during the short two-month span that I spent there. In addition, many of the employees of the organization were walking success stories. They had one day been on the street themselves before the treatment they received at SOME enabled them to regain their health and independence. With a steady job, stable housing, and renewed health, they were devoted to offering others the same services that they had received.

By the end of my time there, I was convinced that this comprehensive approach to care that reaches far beyond simply providing a prescription is the only effective way to help these individuals. This conviction has only grown stronger during the intervening years. As an aspiring physician, I believe that it is crucial to be able to view a patient's illness in a broad and expansive manner by moving beyond

the obvious to explore the often hidden causes for disease. Such causes take the form of a lack of common public health measures, such as proper nutrition, sanitary living conditions, stable housing, and supportive social networks. Inequalities in society that prevent one from obtaining such goods are also to blame. Examples include a poor education, inability to qualify for government assistance such as food stamps, welfare, or Medicaid, and practices that perpetuate divisions in housing based on race. In any case, to effectively treat the existing acute or chronic illness, one must also address these social determinants of an individual's health.

From my time spent at SOME, it seems that homeless individuals combat a higher number of these issues than any other group in society. Thus, analyzing their health, or lack of it, and the treatment necessary to enhance their capability to live a functional life is the focus of this paper. Philosophical principles applied to observed health outcomes can provide a moral argument for society's obligation to supply needed services to this population.

Health as a Moral Right

In *Just Health,* Norman Daniels provides an appropriate philosophical framework to examine the health of the homeless population. Daniels extends Rawls's theory of justice as fairness to a topic that Rawls neglected: the inequalities created by disease and disability. Personal experience will allow most everyone to understand how the loss of function suffered by an individual facing disease or disability reduces his range of opportunities as compared to someone else who is healthy or fully functional. Thus, Daniels argues that "health is of special moral importance because it contributes to the range of opportunities open to us[1] This range of functionings available for an individual to choose from may also be understood as his capability. As a result, the socially controllable factors that contribute to health are also of special importance because they protect individuals' opportunities in life. However, Daniels' argument moves past the need for provision of the determinants of health that are typically considered,

[1] Daniels, Norman. *Just Health, Meeting Health Needs Fairly*. New York, NY: Cambridge University Press, 2008. 21.

namely medical services and traditional public health measures. He includes the need to consider broader social determinants of health such as education, access to adequate housing, life-style stress, and the type of employment available.

This argument requires broadening the way that today's society typically views the protection of health. By this standard, equal access to health care is not sufficient to provide justice in the distribution of a population's health. Rather, one must also address the socially controllable factors that lead to health inequalities. This radical argument would have huge implications for delivery of healthcare if it were to be used as the guiding principle for allocating resources. Namely, it would require a much more comprehensive array of services that seeks to address facets of individual's lives that indirectly influence health.

Daniels also provides an expansive list of every individual's health needs. Health needs are defined as "those things we need in order to maintain, restore, or provide functional equivalents (where possible) to normal species functioning (for the appropriate reference class by gender and age)."[2] The list of needs includes: adequate nutrition; sanitary, safe, unpolluted living and working conditions; exercise, rest, and important lifestyle features such as practicing safe sex and avoiding substance abuse; preventative, curative, rehabilitative, and compensatory medical services; nonmedical personal and social support services; and an appropriate distribution of other social determinants of health.[3] This list certainly extends beyond the factors normally considered necessary for good health. In doing so, it encourages discovery of the diverse underlying influences that nearly every facet of one's life has on health and therefore capability.

In an ideal society, recognizing these connections would be followed by a shifting of resources to correct the injustices that lie far upstream of health outcomes in order to meet all individuals' health needs. In reality, this is impossible due to economic constraints. Health is but one concern to which

[2] Daniels 42.
[3] Daniels 42-43.

funds and energy are allocated, even if it is an important one. In addition, a role for personal responsibility remains amidst the consideration of socially determined factors. Provision of opportunity-expanding resources generates an individual accountability to utilize these services to expand functioning.

Nevertheless, determining the degree of influence the previously listed health needs and social determinants exert in the lives of individuals becomes necessary. The chronically homeless serve as an ideal case-study for practical application of Daniels' principles. The majority of the health needs of this group remain unmet due to their living situation. In addition, social determinants of health often play a role in their fall to such a position as well as in their inability to escape from it. Therefore, observing the health outcomes that prevail in the absence of these provisions can speak to the role of the social determinants of health in determining capability. Though operated on the community level, SOME provides an example of what it looks like to integrate Daniels' principles into patient care. The organization aims to address the broad health needs and underlying causes of problems through their delivery of comprehensive services.

A close look at the homeless reveals that social determinants and the failure to meet the broadly defined list of health needs play a central role in the health of every individual. First, I identify the problems faced by defining homelessness and enumerating the health problems most commonly associated with the condition. Secondly, I identify the population's most common barriers to receiving care, analyze various models of treatment provision that currently exist, and make suggestions for allocating scare resources in order to provide the most effective treatment. This section also considers the role that personal choice of homeless individuals plays in their utilization of the services provided. Finally, I consider society's moral obligation to provide services to this population.

Part 1: Defining the Problem

What is Homelessness?

According to the Stewart B. McKinney Act (1994), an individual is considered homeless if he or she "'lacks a fixed, regular, and adequate night-time residence; and... has a primary night time residency that is: (A) a supervised publicly or privately operated shelter designed to provide temporary living accommodations... (B) An institution that provides a temporary residence for individuals intended to be institutionalized, or (C) a public or private place not designed for, or ordinarily used as, a regular sleeping accommodation for human beings.'"[4] This vague definition suggests a wide range of conditions that may all be technically classified as homelessness but that have vastly different implications for health. Viewing homelessness and its effects in three progressive stages presents a useful conceptual model.

Individuals in the first stage of homelessness are classified as "precariously housed." They are constantly on the brink of homelessness, with a tenuous living situation that may include doubling up with friends or paying extremely high proportions of their resources for rent.[5] Though the insecure nature of their housing represents a source of stress in the lives of these individuals, no unique health implications are associated with this group. They are not included in counts of homeless individuals, though one setback may push them out of housing and onto the streets.[6]

Stages two and three consist of individuals who are "literally homeless." For some reason, these individuals have found it necessary to live in emergency shelters or transitional housing for some period of time.[7] Individuals who have recently become homeless (within the past nine months) are classified to be in stage two of homelessness. The current economic recession plaguing the country is causing a

[4] Who is Homeless?." National Coalition for the Homeless, July 2009. Web. 27 Apr 2010. <http://www.nationalhomeless.org/factsheets/who.html>.
[5] U.S. Department of Housing and Urban Development. *The Third Annual Homeless Assessment Report to Congress.* July 2008. Web. 19 Mar. 2010. < http://www.hudhre.info/documents/3rdHomelessAssessmentReport.pdf>.
[6] Belcher, John, Alwilda Choller-Jaquish, and Mike Drummond. "Three Stages of Homelessness: A Conceptual Model for Social Workers in Health Care." *Health and Social Work* 16.2 (1991): 87-93. Web. 8 Mar 2010.
[7] U.S. Department of Housing and Urban Development. *The Third Annual Homeless Assessment Report to Congress.*

significant increase in this form of homelessness. The National Alliance to End Homelessness estimates that 1.5 million more people will be forced into homelessness over the next two years.[8] These individuals experience various psychological problems such as depression, low self-esteem, alienation, and powerlessness. In addition, they face many of the diseases commonly associated with homelessness and may struggle with substance abuse problems. Yet, they only access medical care on an episodic or emergency basis.[9]

The third and final stage is chronic homelessness. Chronic homelessness exists in the case that "an unaccompanied homeless disabled individual has either been continuously homeless for a year or more or has had at least four episodes of homelessness in the past three years."[10] The most recent data suggests that there are currently 124,000 chronically homeless individuals in the United States, accounting for 23% of the entire homeless population.[11] However, exact numbers can be difficult to obtain because data collection depends on self-report or report by care providers, which may be unreliable. After losing their social support network, individuals often resign themselves to street life and disconnect from mainstream society. They are the group most likely to be found sleeping in places not meant for human habitation, such as on park benches, in cars, or under bridges. As a result, this population experiences the most pervasive health needs, ranging from psychological disorders to substance abuse problems to chronic diseases. The accumulation of the adverse effects of facing the harsh conditions of the street necessitates a method of treatment that is comprehensive and seeks to rehabilitate the whole person.[12] Thus, this final stage of homelessness allows for examination of the

[8] PBS. "Facts and Figures: The Homeless." June 2009. Web. 19 Mar. 2010. <http://www.pbs.org/now/shows/526/homeless-facts.html>.
[9] Belcher et al.
[10] U.S. Department of Housing and Urban Development. *The Third Annual Homeless Assessment Report to Congress.*
[11] National Alliance to End Homelessness. "Chronic Homelessness Brief". March 2007. Washington D.C.
[12] Belcher et al.

cumulative effects of a life devoid of all measures that society may employ to preserve health. This analysis addresses the problems faced by this group.

The Elderly Homeless: Long-term implications of a lack of care

Perhaps the best place to begin in the search for detrimental effects is with a snapshot of the most extreme example possible: elderly homeless individuals. Within this group, the problems associated with homelessness compound the typical conditions associated with aging. Fifty years and older is generally used to designate the elderly in this population because their difficult life experiences cause them to biologically resemble members of the community that are 10 to 20 years older[13] This fact alone illuminates the high proportion of health problems to be expected within this population, who comprise between 14.8 and 28% of the homeless. Indeed, studies show that they tend to be in poorer physical and mental health than both housed individuals of their own age and homeless individuals that are younger.[14] Elderly homeless individuals are especially likely to face eye and dental problems, arthritis, hypertension, circulatory problems, lung disease, stomach ailments, glaucoma, asthma, anemia, diabetes, and sensory impairment.[15] They are especially prone to develop lice and scabies infections and are more susceptible to contagious diseases such as tuberculosis and respiratory infections due to depressed immune systems and poor hygiene. Depression is the most common mental illness among older homeless individuals due to stress, unmet needs, and physical illness that they face. Significant substance abuse, mainly in the form of alcoholism, also exists among the chronically homeless.[16] This extensive catalog of ailments illustrates the results of a lifetime of exposure to negative social and environmental factors that influence health.

[13] Stergiopoulos, Vicky and Herrman, Nathan. "Old and Homeless: A Review and Survey of Older Adults Who Use Shelters in an Urban Setting." *Can J Psychiatry* 48.6 (2003): 374-380.
[14] Garibaldi, Brian, Conde-Martel, Alicia, and O'Toole, Thomas. "Self-Reported Comorbidities, Perceived Needs, and Sources for Usual Care for Older and Younger Homeless Adults." *J Gen Inten Med* 20 (2005): 726-730.
[15] Stergiopoulos and Herrman.
[16] Bureau of Primary Health Care. "Homeless and Elderly: Understanding the Special Health Care Needs of Elderly Persons Who Are Homeless." *BPHC Program Assistance Letter* 2003-03.

Despite suffering from this formidable list of illnesses, older homeless people are not any more likely to seek care than their healthier, younger counterparts due to greater real and perceived barriers. For one, they have difficulty accessing shelter facilities as a result of their impaired mobility and physical limitations, such as an inability to climb stairs or sleep on the floor.[17] In addition, they may suffer from dementia as a result of organic diseases such as Alzheimers, or as a result of alcohol use or head injury. The memory problems, poor judgments, and cognitive impairments that result from the disease make it especially difficult to maintain treatment regimens required by the chronic illnesses that they have. Finally, their frailty makes them easy targets for assault and robbery in shelter environments and may encourage them to avoid such areas.[18] In conjunction, these factors result in each decade increase in age to be associated with a 20% decrease in the likelihood of health care contact in the year before death.[19] These data suggest that the sources of aid that exist for elderly homeless people are incompatible with their needs and ability to seek care. Perhaps needed services have been inadequate for their entire lives and compounded their health problems even further. In any case, this information suggests that any program aiming to address the needs of this population must take into consideration barriers to service utilization.

This initial glimpse into the lives of the homeless paints a grim picture of the prognosis of individuals who must live without access to medical care and the most basic standards of public health. The possibility of expanding their capability to a point that would allow independent participation in society seems highly unlikely. Yet, in order to assertively implicate social determinants in this scenario, it is necessary to ensure that these conditions are not largely a result of old age. Are such detrimental effects characteristic of all those who experience chronic homelessness or do they only manifest themselves after a lifetime of exposure on the streets?

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[17] Stergiopoulos and Herrman.
[18] Bureau of Primary Health Care. "Homeless and Elderly: Understanding the Special Health Care Needs of Elderly Persons Who Are Homeless."
[19] Garibaldi et al.

The Complex Relationship between Homelessness and Health

Though outcomes are slightly less drastic, the insidious nature of health problems among the elderly homeless may be generalized to the chronically homeless population as a whole. While only one-fourth of the housed population suffers from chronic diseases, one-third to one-half of the homeless population endures at least one chronic disease.[20] The most prevalent chronic illnesses include hypertension, diabetes, heart disease, COPD, peripheral vascular disease, and neurological disorders. Chronic infectious diseases such as HIV/AIDS and Hepatitis C, as well as major mental illnesses such as major depression, bipolar disorder, and schizophrenia are also highly prevalent.[21] However, one must be hesitant to generalize about the prevalence of certain diseases among the homeless because doing so may mask important facts about individuals within this very diverse population. Indeed, collecting data about the specific percentages of homeless individuals with chronic diseases can be difficult due to the transient nature of their existence and definitional ambiguity inherent in self-reporting. Nevertheless, the health of homeless individuals is significantly worse than that of even poor, housed individuals. The relationship between homelessness and health that leads to this disparity is a complicated one whose directionality is difficult to ascertain. However, an understanding of this relationship sheds light on the role that social determinants of health play in dictating an individual's capability.

One possible explanation is that health problems precede and play a causal role in homelessness. For example, an untreated mental illness or substance abuse problem may impair the sick individual's ability to function in society. As a result, he or she loses his or her job and ends up on the street due to a lack of income. Indeed, a survey conducted by the U.S. Conference of Majors cited

[20] Zerger, Suzanne (National Health Care for the Homeless Council). "A Preliminary Review of the Literature: Chronic Illness and Homeless Individuals." April 2002. Web. 9 Mar 2010 <http://www.nhchc.org/Publications/literaturereview_chronicillness.pdf>

[21] Zerger, Suzanne.

substance abuse and mental illness as two of the top three causes for homelessness.[22] Serious physical illness is another commonly cited risk factor for homelessness.[23]

A lack of key social determinants of health also plays a central role in the transition to homelessness. Lack of affordable housing represents the second most common cause of homelessness.[24] The other most common systemic cause of homelessness is lack of health insurance. One accident or health issue may generate large medical bills that cannot be paid and force an individual out of his or her home. Other common risks include lack of employment and low wages, which may also implicate racial discrimination to some degree.[25] Finally, being illiterate or even just poorly educated may make it more difficult to navigate within society and advocate for one's needs. All of these situations implicate inequalities in society as a causal factor in homelessness and subsequent medical issues.

Secondly, once on the street, many illnesses arise due to the conditions of a homeless individual's lifestyle. Many factors common to homelessness contribute to both acute and chronic illness. For instance, homeless individuals most often complain of acute pathologies including respiratory infections, tuberculosis, and skin infections such as cellulitis or scabies infestations.[26] All of these may be explained to some degree by the environment of homeless living conditions. For one, the suboptimal control of personal hygiene and the unsanitary conditions of the areas in which they sleep contribute to increased susceptibility to these types of illnesses. In addition, constantly being in close proximity to individuals with comparably poor hygiene expedites the likelihood of developing such conditions. Individuals living in shelters come into contact with a mean of 120 other residents in eight

[22] The United States Conference of Mayors. "Hunger and Homelessness Survey." December 2008. Web 4 Apr 2010. < http://www.usmayors.org/pressreleases/documents/hungerhomelessnessreport_121208.pdf>.
[23] "The Basics of Homelessness." National Health Care for the Homeless Council. Web 28 Feb 2010. <www.nhchc.org/Publications/basics_of_homelessness.html>.
[24] The United States Conference of Mayors.
[25] "The Basics of Homelessness." National Health Care for the Homeless Council.
[26] Popescu, Gabriel-Adrian, and Ioana Chirca. "The Starry Heaven and the Crowded Shelters: Pulbic Health Risks." *Southern Medical Journal* 103.1 (2010): 3-4.

days. Frequent movement of individuals from shelter to shelter is therefore capable of facilitating the spread of such diseases across cities fairly rapidly.[27] Constant exposure to environmental elements such as extreme temperature and lack of protection from rain, snow, and sun may also contribute to these infectious diseases by lowering an individual's immunity. Other health problems such as frostbite and burns also pose a threat. Thus, these illnesses do not arise at random but stem from a lack of adequate public health measures such as sanitary sleeping arrangements.

Social and environmental factors also contribute to the chronic illnesses seen most frequently among the homeless. Nutritional deficiencies due to lack of a choice and lack of access to healthy foods may certainly be implicated in nearly any prevalent chronic disease. In addition, life-style choices that play a dominant role in the culture of street life, such as alcohol, tobacco, and drug use, all have negative health implications. Such actions instigate new health problems such as transmission of HIV through needle use or promiscuity. They also exacerbate existing illnesses, as in seen in the relationship between smoking and respiratory illnesses. As previously mentioned, constant exposure to inclement weather may decrease individuals' immune responses and make them more susceptible to infectious diseases. Finally, elevated stress levels resulting from perpetually operating in "survival mode" in order to avoid victimization on the streets adversely affect both mental and physical health. Elevated levels of stress hormones encourage development of metabolic diseases such as diabetes.[28] Most notably, constant danger takes a toll on psychological well-being and contributes to development or exacerbation of mental illness or substance abuse problems. To further complicate the picture, one disease triggered by any of the above factors may promote the development of another. For instance, obesity resulting from improper nutrition may result in diabetes, hypertension and heart disease.

[27] Popescu and Chirca.
[28] Filardo, Thomas. Chronic disease management in the homeless. In: Brickner PW, Scharer LK, Conanan B, Elvy A, Savarese M, eds. Health Care of Homeless People. New York, NY: Springer Publishing Company; 1985:19–34.

Extending the illustration of the effects of street-life on one's health further is unnecessary to recognize the interconnected nature of health problems.

The third possible relationship between homelessness and health lies in the way daily realities of homelessness complicate the treatment of many illnesses. The standard treatment for diabetes provides an excellent example. First of all, the disease typically requires adherence to a strict diet. This proves very difficult to accomplish when relying solely upon shelters or soup kitchens for meals, because they do not offer specialized diets. Secondly, many patients require regular insulin injections or blood sugar monitoring. The disorganized, unpredictable, and highly mobile nature of the homeless individual's life makes it difficult to follow a rigid schedule or to acquire consistent care. In addition, insulin must be refrigerated to maintain its potency, which is not an option for people without a home. Finally, syringes and alcohol swabs are subject to theft for their value on the street. Together, these factors make the maintenance of this difficult-to-control disease seem to be next to impossible for the homeless.[29] Without proper care, the disease can escalate to have dire consequences for the individual including stroke, blindness, or the need for an amputation. In this case, even individuals who wish to assume the responsibility to care for their health may be prevented from doing so successfully due to factors largely out of their control. Once again, social determinants of health limit the sick individual's capability.

Any of these explanations alone is overly simplistic. In order to fully comprehend the health challenges facing the homeless, it is necessary to think critically and imaginatively. One must be willing to blur lines of cause and effect and suggest connections between facets of life that seem unrelated upon an initial, superficial examination. It seems that in most cases "the medical disorders of the homeless are common illnesses, magnified by disordered living conditions, exposure to extremes of heat and cold, lack of protection from rain and snow, bizarre sleeping accommodations, and overcrowding in

[29] Zerger, Suzanne.

shelters. The stress of street life, psychiatric disorders, and sociopathic behavior patterns obstruct medical interventions and contributes to the chronicity of disease."[30] Regardless of cause, the prognosis remains grim: the rates of mortality are three to four times higher in the homeless population than in the housed population.[31]

These data and illustrations elucidate the complex and influential role the social determinants of health play in the lives of the homeless population. Recurrent trends pointing to several social determinants of health that especially impact the lives of these individuals also arise. First, lack of a good education can result in low-wage jobs that contribute to economic instability and potential homelessness. Lack of knowledge also reduces individuals' ability to make choices that allow a healthy lifestyle or even to read treatment instructions. Secondly, inability to acquire housing arrangements that are sanitary and offer sufficient protection from the elements and transmission of disease poses a huge problem. Finally, lack of access to adequate nutrition, needed mental and physical health care, and addiction services exacerbate preexisting conditions. The approach to care at SOME recognizes the role of all of these factors in their client's lives. For individuals choosing to seek their care, they try to rectify each of these issues in addition to treating disease symptoms through the diverse and comprehensive services that they offered. Addressing these underlying issues is the first necessary step to increasing homeless individuals' capability to function in society.

Part 2: Seeking a Solution

The Most Common Barriers to Care

Before evaluating the various options that are currently available for the care of homeless individuals, one must understand the most prominent barriers these individuals face to utilizing the services provided. Several obstacles result from practical, structural measures. For instance, a lack of the financial resources needed to obtain care is a common culprit. In some cases, this means the

[30] Brickner et al. (1986) in Zerger, Suzanne.
[31] Gelberg (1996) in Zerger, Suzanne.

inability to obtain any form of medical insurance. However, sometimes even individuals capable of obtaining indigent insurance cannot keep it current or cannot find a hospital or provider in their area who will accept it. Also, even private insurance covers health needs according to a very narrow definition. No insurance policy covers the issues associated with social determinants of health that have been discussed. This scenario implicates the lack of transportation to medical facilities as another structural barrier to care. Also, a lack of comprehensive, recuperative services within communities poses a problem.[32] These infrastructural deficiencies impact rural communities the greatest due to the existence of a smaller number or providers and sites to receive care.

Other obstacles largely result from individual perceptions or disabilities. For instance, mental illness or physical disability inhibits an individual's mobility or ability to seek care. In addition, embarrassment about appearance and hygiene as well as nervousness about filling out forms and answering questions causes individuals to postpone seeking care. Others choose to avoid care due to bad past experiences with medical professionals. For instance, many homeless individuals report reluctance to seek care because they feel that healthcare providers lack compassion for them and treat them disrespectfully.[33] Finally, some homeless individuals do not even acknowledge that they have a need for care. Even though the health of the homeless is consistently found to be worse than the housed poor, between one-third and two-thirds of the homeless self-report their health as good or excellent. Similarly, though homeless individuals in non-shelter locations were observed to have more health problems than shelter users, they reported a comparable health status.[34] These findings suggest that as homelessness becomes a normal state, the criteria necessary to identify symptoms as problematic become more stringent. Consequently, identification of health problems becomes less

[32] Zerger, Suzanne.
[33] Popescu, Gabriel-Adrian, and Ioana Chirca.
[34] Pilivian, Irving, Alex Westerfelt, Yin-Ling Wong, and Andrew Afflerbach. "Health Status and Health-Care Utlilization among the Homeless." *Social Service Review* 68.2 (1994): 236-253. Web. 28 Feb 2010. <www.jstor.org/stable/30012239>.

likely. Common stereotypes of this population discourage sympathy within the general public and facilitate the appearance and growth of these types of barriers.

The third major set of obstacles to care results from the homeless lifestyle. As mentioned previously, the ability of patients to comply with treatment for chronic diseases is greatly compromised due to the unpredictable nature of their living conditions. Perhaps the most relevant but least often acknowledged barriers that homeless individuals face are their significant competing needs. First and foremost, they must be concerned with assuring that their basic needs for food, shelter, and protection from weather and violence are met. Worries about health care, especially about taking measures to prevent problems yet to manifest themselves, are much less pressing and thus take a backseat. In fact, research finds that those with frequent subsistence difficulty were about one-third as likely as those with infrequent difficulty to have a regular source of care and almost twice as likely to have gone without needed medical care.[35] Thus, the need to focus on day-to-day survival often causes the homeless to delay seeking care for an illness until it is an acute concern that demands attention. The implications of this reality are significant for two reasons. For one, it presents a problem for health care providers and harms the sick individual. A disease that has progressed to the point where it can no longer be ignored is much more difficult to treat and may even be past the point of rehabilitation. Implications for an approach to treating these individuals also arise. In this case, diagnosing their illness and releasing them right back into the challenging conditions of the street can be counter-productive. In order to make any lasting improvement in their health and capability, one must first address underlying environmental issues by providing the resources necessary to live a secure existence. This constitutes yet another argument in favor of the importance of addressing social determinants of health. Once again, the model of care provided by SOME addresses this significant barrier.

[35] Gelberg, Lillian, Teresa Gallagher, Ronald Anderson, and Paul Koegel. "Competing priorities as a barrier to medical care among homeless adults in Los Angeles." *American Journal of Public Health* 87.2 (1997): 217-220.

Potential Solutions

A problem of this magnitude requires attention on both the federal and local level. In addition, any approach to the treatment of these individuals must bear in mind both the numerous, often simultaneously occurring, illnesses faced by the homeless as well as the barriers that they face to utilizing care that is offered. Addressing both of these issues makes it possible to increase a homeless individual's capability. Various models exist that emphasize different aspects of care and differ significantly in the way that they are funded and managed. However, the majority of successful programs share in common a very important feature: all recognize and address to some extent the impact of the social determinants of health that play an especially significant role in the lives of the homeless. Because there are only limited resources available to allocate to such programs, the real question becomes how to do so most effectively. The following analyses of models of care that exist seek to shed some light on this critical issue.

The Health Care for the Homeless Program (HCH) is the only federal program with the sole responsibility of addressing the critical primary health needs of homeless individuals. This competitive grant program was first established with the McKinney Homeless Assistance Act of 1987 after Robert Wood Johnson/Pew Memorial Trust projects proved successful in 19 cities. The federal appropriations for this program have been increasing since 2002, with $191 million designated for this use in 2009.[36] Rather than establishing a nationally standardized program implemented identically in different cities, this program collaborates with providers at the community level that initiate, design, and manage the projects. Any organization intending to deliver high-quality, accessible, and comprehensive health care to people experiencing homelessness is eligible to apply. Such organizations include public and private non-profits, faith-based organizations, hospitals, local health departments, shelters, and homeless coalitions. Each project must provide primary health, mental health, addiction, and social services to

[36] "Health Care for the Homeless Program." National Health Care for the Homeless Council, 27 Jan 2010. Web. 28 Feb 2010. <http://www.nhchc.org/Advocacy/HCHProgramFactSheet0509.pdf>.

patients while also engaging in intensive outreach and case management to link clients with needed services.[37] A network of 211 HCH grantees in all 50 states, the District of Colombia, and Puerto Rico served 742,588 men, women, and children in 2007.[38]

Examining the specific operations of one of these projects gives a concrete example of this initiative. Health Care for the Homeless in Baltimore was established in 1985 as one of the initial trial projects and is now a nationally-recognized model for care to underserved populations.[39] HCH provides comprehensive medical services including pediatric, adult, and geriatric primary care, screening, health education, convalescent care, and referrals for specialty medical care as well as a comprehensive dental program. HCH addresses mental health needs by offering crisis intervention, psychiatric services, inpatient and outpatient therapy, and support groups that promote overall psychological wellness. In addition, HCH offers creative and individualized addictions therapy through the only state-certified outpatient addictions therapy program in Maryland specifically designed to address the circumstances of homeless individuals. In addition to attending to medical needs, HCH addresses the social determinants by employing case-workers who strive to secure food, clothing, shelter, public benefits, and employment for clients. Most importantly, regular case conferences between all of a patient's care providers facilitate an interdisciplinary care plan for each patient. Finally, the agency runs many specialized programs that seek to find more permanent housing for clients.[40]

There are several strengths of this arrangement for provision of care. First, provision of funding from a federal source guarantees a certain degree of financial security in comparison to projects financed solely by charitable donations or private companies. In addition, a federal grant carries with it the expectation that the project will accomplish its proposed purpose. This accountability to

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[37] Zerger, Suzanne.
[38] "Health Care for the Homeless Program." National Health Care for the Homeless Council.
[39] "History and Mission." Health Care for the Homeless, Inc. Web. 9 Mar 2010. <http://www.hchmd.org/history.shtml>.
[40] "Medical Services." Health Care for the Homeless, Inc. Web. 9 Mar 2010. <http://www.hchmd.org/medical.shtml>.

demonstrate outcomes mitigates irresponsible use of funds. Another notable strength arises from delegating management to the community level. This enables projects to address needs unique to the city in which they are operating and offer the most individualized care possible. Finally, perhaps the greatest strength lies in the emphasis on providing comprehensive services that move far beyond the basic measures of health to address lifestyle factors affecting an individual's pursuit of health.

Unfortunately, relying on government provision alone is not nearly sufficient. Programs established through the donations and efforts of charitable or private organizations also play an important role in providing care. SOME provides a model of this type of organization. Though SOME does receive some funding from government and foundation grants, nearly half of its revenue comes from private contributions.[41] This community-based organization was founded as a Catholic soup-kitchen forty years ago. Now it has expanded into an organization that addresses the majority of the social determinants of health through the comprehensive services it provides. Within the realm of traditional health care, SOME offers primary care, lab work, referrals, podiatry, ophthalmology, prescription provision and full dental services. Mental health services offered include psychiatrist appointments, therapy sessions, and support group meetings. There are also a variety of services that address the broader health needs of individuals. For instance, comprehensive addiction rehabilitation includes a ninety-day visit to Exodus House in rural West Virginia as well as transitional housing before and after the program. A Center for Employment Training teaches participants hard and soft skills necessary to secure a job that pays a living wage. SOME owns many different forms of affordable and safe housing throughout the city, ranging from all-male SROs to housing for families. The organization also operates shelters targeting the needs of certain groups, such as individuals going through psychiatric crisis. Case-workers coordinate all of these services and strive to obtain health insurance,

[41] SOME Annual Report 2008. So Others Might Eat. P. 18. Web. 9 Mar 2010. <http://www.some.org/docs/2009%20Annual%20Report.pdf>.

housing, and other external resources for clients.[42] The combination of services provided first addresses the root causes of clients' problems, such as addiction or lack of housing. Fulfilling these needs empowers individuals who choose to value health to assume greater agency in pursuing healthy lives.

A new and rather innovative model has arisen in recent years that combines private funding with public institutions to offer services to the homeless in the hospital setting. One example exists at the Good Samaritan Hospital in Dayton, Ohio. This hospital opened its Samaritan Homeless Clinic in 1992 after receiving a generous gift from an anonymous donor. This clinic also offers a wide range of health and wellness services in one environment in accord with its commitment to caring for the whole person.[43] The clinic offers comprehensive medical services including immunizations, lab work, prescriptions, and screenings for various diseases and cancers. It also supplies professional dental, podiatry, and visual services. Psychiatrists administer and monitor psychiatric medications, and mental health counselors provide therapy and chemical addiction counseling. Social workers coordinate basic case-management and referrals to external agencies for services. Additionally, they help to complete applications for Medicaid or Social Security Disability and provide hygiene kits, shoes, and transportation. Finally, the clinic offers classes on topics such as health education and stress and anger management.[44] Despite the rich array of services offered, no patient is turned away due to inability to pay, and no patient is sent a bill for on-site services. Once again, this program targets all of the major barriers patients may face to attending to health needs.

Another, smaller-scale support system for homeless individuals in hospitals takes the form of special recuperation rooms. After receiving treatment for acute problems, homeless individuals remain in these rooms for up to 15 days recuperating rather than being pushed back out onto the street

[42] SOME Annual Report 2008. So Others Might Eat. p. 5-13.

[43] "About the Samaritan Homeless Clinic." *Good Samaritan Hospital*. Premier Health Partners, 2010. Web. 4 Apr 2010. <http://www.goodsamdayton.org/gshservices.aspx?id=21418>.

[44] "Programs and Services." *Good Samaritan Hospital*. Premier Health Partners, 2010. Web. 4 Apr 2010. <http://www.goodsamdayton.org/gshservices.aspx?id=21420>.

immediately.[45] Though this initiative is not nearly as comprehensive as the Good Samaritan clinic, it still acknowledges the confounding influence of environmental factors. Forcing homeless individuals to face harsh street conditions immediately after receiving care almost certainly spells disaster for their recovery. Protecting them from adverse street conditions and allowing them continued access to medical facilities for two additional weeks can significantly decrease their need for treatment for the same, or a closely related, problem in the near future.

The model of care demonstrated by these three efforts possesses its own set of benefits and drawbacks. On one hand, the largely private funding allows flexibility in use that would not be present in programs funded mostly with government money. This makes it possible to try experimental methods that improve upon currently existing models. However, private funding is not guaranteed to be stable and sufficient to meet operating needs. Relying upon donors and volunteers to match growing need in trying economic times can result in a stressful and uncertain operating climate. There are also several advantages to providing care through a public institution such as a hospital. For one, they are already established as treatment centers and have sufficient resources on hand. In addition, hospitals are the main source of care used by many homeless individuals. Providing services beyond acute care at these locations is highly practical because it treats individuals in a more efficient and effective way in a climate already familiar to them. This can help to decrease barriers associated with individual perceptions and resulting discomfort, thereby increasing the likelihood people in need will actually seek care.

All of these programs share a common commitment to offering treatment that extends beyond prescribing medication for illnesses. They seek to rehabilitate the whole person by confronting problems in all aspects of the individual's life. The "Housing First" tactic deals primarily with rectifying

[45] Wykes, Sara. "Stanford Hospital & Clinics Boosts Homeless Healthcare ." Stanford Hospital and Clinics, 23 Apr 2008. Web. 4 Apr 2010. <http://stanfordhospital.org/newsEvents/newsReleases/2008/boostsHomelessHealthcare.html>.

social determinants in an even more progressive manner. This approach "minimize[s] the time people are homeless, including time spent in emergency shelters and/or transitional housing."[46] The primary focus of services is to find appropriate affordable housing. Service provision shifts to dealing with long-term problems only after housing stability has been achieved. At this time, services tailored to the unique needs of each individual promote cost-effective improvement of health outcomes. For instance, chronically homeless individuals gain access to intensive, ongoing supports and services for their problems, such as mental illness or addiction.

Innovative community-based non-profits pioneered the supportive housing movement in the mid-eighties. In the intervening decades, the model has caught on and is now supported at many different levels. The federal government directs the largest initiatives through the support of the Stewart B. McKinney Homeless Assistance Act and the leadership of the U.S. Department of Housing and Urban Development (HUD). Since 1994, the HUD utilizes a "Continuum of Care" approach that helps communities plan and implement housing resources that will assist homeless individuals to leave homelessness behind and reconnect with the community. States such as New York, Connecticut, Minnesota, and California have implemented supportive housing initiatives and subsequent studies of their efficacy. Foundations such as the Robert Wood Johnson and Ford Foundations have also joined the movement to foster housing initiatives that seek to end homelessness. Finally, national non-profit intermediaries, such as the Corporation for Supportive Housing, have been established to augment the quantity and quality of supportive housing available.[47]

Many of these programs designate housing units specifically for homeless individuals with chronic conditions such as mental illness, substance abuse, AIDS, or other debilitating health problems. In fact, providing supportive housing has become an increasingly popular strategy for serving the

[46] "Frequently Asked Questions about Housing First for Individuals and Families." National Alliance to End Homelessness, 27 Nov 2006. Web. 4 Apr 2010. <http://www.endhomelessness.org/content/article/detail/1424
[47] Zerger, Suzanne, p. 16-17.

chronically homeless. Nearly ten years ago the federal government committed to end chronic homelessness and has actually made large strides in the direction of achieving their goal. Between 2005 and 2008, chronic homelessness fell nationally by 28 percent and declined even more steeply in some communities making special efforts.[48] Providing permanent housing coupled with supportive services targeting specific needs according to the Housing First model has been the most successful intervention tool. Housing is most often provided in the form of Section 8 Housing Vouchers or subsidies through the McKinney-Vinto Homeless Assistance Program. Services provided include health care, substance abuse treatment, mental health treatment, employment counseling, and connections with mainstream benefits like Medicaid. Another key to success has been targeting services to individuals with the most extensive needs, such as those that have spent substantial time in hospitals, correctional facilities, or other institutional care facilities.[49]

Earlier discussions of the importance of prominent social determinants of health help to explain the significant positive impact that supportive housing wields on the health of a chronically homeless individual. The safety and stability that programs such as this introduce into an individual's life arguably exerts the most influence. Removing someone from the streets also removes the need to constantly be on guard against violence, theft, or other dangerous situations. In addition, it is no longer necessary for the individual to be preoccupied with securing the "creature comforts" necessary to survive. Thus, the newly housed individual may engage himself in addressing chronic illnesses and seeking rehabilitation for psychological and substance abuse problems.[50] SOME once again provides an example of the application of this principle through the model of their addiction rehabilitation program. Individuals entering the program are placed into Kirwin House immediately following their initial assessment and acceptance and reside there while receiving medical and dental services necessary for movement to the

[48] National Alliance to End Homelessness. "Chronic Homelessness Brief".
[49] National Alliance to End Homelessness. "Chronic Homelessness Brief".
[50] Wright, Maurice. Personal INTERVIEW. 15 Mar 2010.

three month program in West Virginia. This safe house removes them from the temptations and distractions that they face on the street, fulfills all of their basic needs, and provides a sense of security. In this environment, they begin to focus on taking care of themselves and gain the strength they will need to face their addictions.

All of the models discussed take the first step in augmenting the capability of the homeless. However, they also require investment of a portion of society's scare resources. Fortunately, an economic incentive for providing care to these individuals exists. Homeless individuals are most likely to rely upon the most expensive types of health services due to a lack of adequate access to preventative and routine care. Hospitals are the main source of care for the homeless. Nearly half of the homeless medical hospitalizations are for conditions related to illness that are easily preventable with more routine care.[51] Delaying seeking any form of treatment until absolutely necessary in this way is very costly to society. In fact, the total preventable costs associated with homelessness for the NYC public hospital system are approximately 100 million dollars per year,[52] and this problem is not unique to New York. Providing a means to obtain better primary care will therefore benefit both homeless individuals and society.

Analyzing the various treatment models informs the remaining task of determining the most effective way to provide services that work toward renewing the capability of the homeless. I believe that the answer rests in a creative coordination of comprehensive service provision that addresses the broadly defined health needs of individuals. Health insurance that guarantees access to basic medical care for physical and mental illness is a starting point but is not sufficient. This paper has shown that the needs of homeless individuals extend beyond the realm of care covered by even the best private insurance plan. The recently passed health reform legislation represents a move toward more ready access to care for homeless individuals. For one, nearly all homeless individuals will be eligible for

[51] Zerger, Suzanne.
[52] Zerger, Suzanne.

Medicaid and therefore able to receive primary care more easily. In addition, the legislation includes initiatives aimed at coordinating care between various providers in order to more effectively manage chronic conditions and reduce emergency room usage.[53] However, many of the provisions for greater utilization of collaborative care are options for the states or grants available that will require significant advocacy work to come to fruition. Thus, years may pass before patients reap any benefits. Even if these programs are implemented, they do not address all of the broader health needs of the homeless.

Thus, programs offering services that target the deficiencies resulting from unequal distribution of the social determinants of health are still necessary. These programs should first address the 'creature comforts' by providing shelter, food, and a sense of security and stability. Doing so will free patients from competing needs so they can engage in improving their own health. Secondly, these programs should offer rehabilitative services such as addiction treatment programs and counseling services to assist in coping with debilitating mental problems. Finally, programs should empower their patients by educating them about basic health topics or economic strategies so that they may one day care for themselves. This combination can begin to expand the opportunities available to individuals to allow them to reach the highest level of functioning possible given their natural individual abilities. It seems that such extensive programs would be very costly and thus impractical given the limited resources available. However, addressing the underlying issues and effectively coordinating support systems may allow such endeavors to ultimately pay for themselves, as seen in the example of the Supportive Housing programs.

Analyses of supportive housing initiatives show that reducing reliance costs associated with services such as shelter, ambulances, jail, emergency rooms, and behavioral health treatments, offsets the cost of providing permanent housing.[54] For instance, analysis of the *New York/ New York agreement to house Homeless Mentally Ill Individuals* found that once placed into supportive housing, a formerly

[53] "What Health Reform Does For Homeless Populations." Corporation for Supportive Housing, March 2010.
[54] National Alliance to End Homelessness. "Chronic Homelessness Brief".

homeless, mentally ill individual reduced his use of publicly funded services by an average of $12,145 per year. This ultimately translates into savings of $16,282 per year for each housing unit constructed, which accounts for 95% of the building and operating costs.[55] Another study found a decrease in emergency room visits by 50%, a decrease in incarcerations by 50%, and a decrease in inpatient days in San Diego by 49%.[56] In addition to covering provision costs, studies have shown that permanent supportive housing does indeed improve health outcomes. A recent study of the impact on homeless, HIV-positive patients found that "'housing homeless individuals and providing them with intensive case management can increase the proportion surviving with intact immunity and decrease overall viral loads…For every 5 patients offered this intervention and for every 3.25 patients provided housing in a program agency, 1 additional patient will be alive with intact immunity.'"[57] Therefore, this program fulfills the goal of efficiently and effectively expanding the capability of homeless individuals by improving individuals' health in a cost-effective manner.

Location of program facilities and details of management are of lesser importance. In fact, flexibility in these areas may actually prove most beneficial by allowing service provision to be customized to the specific needs of the population being served. Programs may be effective whether they are based out of a clinic, hospital, or shelter as long as efficient case management occurs. Finally, contributions from all levels will be necessary to fund these programs. Provision of federal money to community-based organizations seems to be the most reliable and effective method. However, the government alone cannot be expected to carry this load. Non-profit organizations and private charitable contributions also command a necessary role.

The Role of Personal Responsibility

[55] Zerger, Suzanne, p. 19.
[56] Zerger, Suzanne, p. 18.
[57] National Alliance to End Homelessness. "Chronic Homelessness Brief".

While considering potential solutions, the role of personal responsibility of the homeless individual must not be overlooked because it is what will ultimately determine any individual's health and capability. Society must first fulfill its obligation to make available the services necessary to expand the capability of debilitated homeless individuals to a minimal acceptable level of functioning. Individuals in need must then choose to utilize the resources made available to them. Each man or woman must determine that health is of value to him or her and freely choose to make changes in his or her own life to pursue this end. Though the majority of society would not agree with the decision or understand it, low-functioning homeless individuals may decide that they are content with the life they are living. I do not suggest that most homeless individuals would willingly choose to live on the street rather than in a home. The decision is much more nuanced than that. It is possible that they are oblivious to alternate possibilities or unaware of what is required to initiate change in their lives. Alternately, they may be set in the habits they have developed over the course of their life and feel that the major changes they would have to make in their lives are too difficult. The choice and action of the individual have to be honored in either case.

I must suggest that this particular scenario merits extra prompting to utilize offered services. Individuals may be so depressed and hopeless due to their living conditions that they cannot comprehend the possibility of a brighter, less painful future. They also may not realize the extensive positive repercussions certain changes may cause due to a lack of education on the topic. Thus, these individuals should not be left to make such important decisions completely on their own. Providing sufficient information to enable them to understand what change entails and the potential outcomes is certainly required. Continued encouragement to initiate change after an initial refusal may also be appropriate. Such measures may be viewed as overly paternalistic in the case of normally functioning individuals. However, in this case paternalism facilitates empowerment. After trying something they never would have done through their own incentive, they may awaken to new potential that they

previously did not know existed. Nevertheless, in the end, the decision to truly capitalize on provided resources in order to make changes that extend capability lies with the patient.

Once again, my experience at SOME provides a vivid illustration of this concept. One afternoon, I brought a woman back to a room be triaged and began to ask her the basic questions that had become standard over the past six weeks. Expecting the routine answers I had become accustomed to, I was initially shocked by her response. Rather than enumerating various ailments, she looked me in the eye and told me that she was addicted to crack. She repeatedly expressed that she wanted to stop using but could not escape her addiction because she was constantly surrounded by other addicts. In the ensuing discussion, this street-hardened woman placed her last hope in me, a young, naïve girl whose limited life experiences had clearly been so different from her own. As I sat listening to her, completely humbled, I could see the desperation in her eyes and could not hold back the tears in my own.

Due to the comprehensive services offered by SOME, this encounter yielded a positive outcome.

As soon as our conversation ended, I escorted the woman back into the waiting room and promptly relayed her story to the nurse responsible for admitting patients to the addiction therapy program. This nurse immediately interviewed the woman, and she was in the clinic the next day receiving the medical services she needed to be cleared to leave for West Virginia. This woman had taken the first step toward regaining control of her life. Yet, it is important to recognize that she made the decision to initiate this process. If she had never voiced her desire to overcome her addiction, the physician would simply have treated her hypertensive symptoms and released her back onto the streets. Instead, she decided she could no longer continue as she had been before and reached out to utilize the wealth of resources provided by SOME. In order to successfully control her addiction, she will have to make the decision to remain committed to health every day for the rest of her life. However, the option to make this choice represents a huge step forward in renewing the capability of this woman.

Part 3: A Moral Obligation

Even though homeless individuals may choose not to utilize services, society retains a moral obligation to provide them. Homeless individuals possess significantly decreased capability due to the extensive and debilitating mental illness, physical illness, and addictions they face. In many cases, these illnesses result from unequal distribution of the social determinants of health within society. Poor health may also be perpetuated and exacerbated through environmental influences stemming from unequal access to life's basic necessities such as food and shelter. As a result, society is obligated to augment the range of opportunities available to these disadvantaged citizens by providing the services necessary to improve their health to a level that allows basic functioning within society. However, the level of health required to fulfill this criterion differs between individuals based upon where they are in the course of their life. In other words, equal outcomes for all individuals are not a requirement.[58] Extensive intervention, rehabilitation, and counseling services may be required for a young man suffering from a drug addiction, while provision of palliative medical care may suffice for an elderly man. Finally, society may not select to provide such resources to some individuals while denying others. Even individuals who find themselves homeless due to personal choice that represent squandered capability suffer from unequal distribution of social determinants of health. Once they are living on the street, the previously discussed challenges of the homeless lifestyle entrap them in a cycle of poor health and make escape from the streets difficult. They also deserve a chance for renewal of health and capability through outside aid.[59]

Though inequality in distribution of social determinants of health will never be eradicated, homeless individuals are not doomed to lives of minimal functioning beyond repair. Renewal is possible when society recognizes and addresses the consequences of these inequalities. As in the example of the woman at SOME, the story remains a hopeful one when supportive resources are in place. Even if

[58] This section is informed by: Beckley, Harlan. "Capability as Opportunity: How Anartya Sen Revises Equal Opportunity." *Journal of Religious Ethics*. 30.1 (2002): 107-135.
[59] This section is also informed by Beckley, Harlan.

individuals are never restored to functioning enabling independent participation in society, any improvement in quality of life achieved should be considered a success. Society can most effectively and responsibly seek to expand capability by providing programs that address broadly defined health needs of individuals. Doing so fulfills the obligation to society as a whole as well as to individuals by meeting a homeless individual's broad array of health needs in the most cost-effective manner. As a result, society can move beyond simply providing healthcare to truly fostering health, and therefore capability, in its most disadvantaged population.