Mainstreaming Health Care for Homeless People

In the early 1980s, America witnessed the emergence of mass homelessness for the first time since the Great Depression. "Safety net" programs that had been designed to meet the survival needs of poor, elderly and disabled Americans – programs like Medicaid, public housing, and "welfare" – had manifestly failed to meet the needs of those who became homeless. Several factors partially explain this failure: limited eligibility; dramatically reduced program resources resulting from Federal budget decisions; enrollment barriers due to bureaucratic complexity and inconsistent eligibility determination procedures; and service delivery systems that were insensitive to the needs of utterly impoverished, transient populations with multiple problems.

In response to the massive failure of these *mainstream* safety net programs to meet the needs of the most vulnerable Americans, *targeted* programs with the specific intent of alleviating homelessness were created through the Stewart B. McKinney Homeless Assistance Act and other measures. As mass homelessness has persisted, the targeted programs have grown, and a large "homeless" safety net beneath the mainstream safety net has emerged. The publisher of this paper, the National Health Care for the Homeless Council, represents one part of a homeless services industry that now spends about two billion dollars of Federal funds each year. While the targeted homeless programs do alleviate homelessness for hundreds of thousands of people each year – still just a portion of those in need – and are crucial to homeless persons' very survival, they do not *prevent* homelessness, and do not put an end to homelessness itself.

As mass homelessness has persisted, government officials have begun to understand that the targeted homeless programs are necessary but insufficient, and they now argue that the mainstream programs, with their much larger budgets, should more adequately respond to the needs of homeless people. This new emphasis has been expressed in a series of Policy Academies for state and local policy makers, in numerous pronouncements of the Federal Interagency Council on Homelessness, and in the requirements of various Federal grant programs. The policy direction is called "mainstreaming."

A long overdue examination of the role of mainstream programs has begun. Mass homelessness signifies the failure of numerous systems, and the eradication of homelessness will require significant adjustments to many mainstream public programs, particularly in the areas of health care, housing and income support. This paper very briefly examines the interaction of the health care system with homelessness, and describes an effective approach to mainstreaming in health care that can help to prevent and end homelessness.

Homelessness and Health Care

In 1987, the McKinney Act established a categorical grant program supporting integrated primary care, case management, treatment for mental illness and substance use disorders, and wrap-around services specifically for homeless people. The framers of the McKinney Act consciously chose to create a separate, targeted program, instead of increasing the capacity of existing Community Health Centers (CHCs) or other providers to accommodate homeless populations. They chose to replicate the access-oriented, multidisciplinary model of care that had been developed in a private foundation-supported demonstration program. The Bureau of Primary Health Care within the Department of Health and Human Services soon made the first 109 Health Care for the Homeless (HCH) grants to CHCs, hospitals, health departments, and community-based non-profit agencies.

In 1988, the Institute of Medicine of the National Academy of Sciences confirmed the centrality of health issues to homelessness, declaring in *Homelessness and Health* that (1) poor health causes homelessness, (2) homelessness causes poor health, and (3) homelessness complicates efforts to treat health problems. Numerous studies in the years since have confirmed these basic relationships, documenting the extraordinarily poor health status of homeless people. The necessity of providing health care for people who are homeless and at risk of homelessness was firmly established, and the techniques for extending care to those without homes were well demonstrated.

In 1996, reauthorizing legislation consolidated the HCH program with other Health Center programs, but HCH retained a distinct identity, program requirements and dedicated funding, 8.6% of the overall Health Center appropriation. In FY 2004, the $137 million Federal HCH program supported 172 grantees in 50 states, the District of Columbia, and the Commonwealth of Puerto Rico, serving more than 600,000 homeless persons, still only a small fraction of those who experience homelessness in the United States annually. HCH and other Health Center programs have grown each year in response to persistent advocacy and a Presidential Health Center Growth Initiative that intends to double the number of Health Center users over five years.

The clients of the HCH program are gravely ill, extremely poor, and unable to access other health care providers for a variety of well-documented reasons. Chief among these is lack of health insurance. 71% of HCH clients are uninsured, as are a majority of all surveyed homeless people, compared to 43% of CHC clients and 16% of the general U.S. population.

The Streams of Health Care

In any consideration of health care policy, it is important to distinguish between health care *financing* and health care *delivery* systems. Delivery systems take various forms, but are primarily comprised of private organizations, both for-profit and non-profit. Delivery systems include community-based clinics, large hospital chains, group practices, HMOs and myriad other arrangements for actually providing health care services. All delivery systems derive income from a variety of sources, and it is ultimately the streams of financing that determine who gets care, and who does not.

Today's Mainstream: Private Health Insurance. Most health care services in the United States are purchased with private health insurance. Health insurance is most commonly provided as a benefit of employment, though employer-sponsored health insurance is declining; individuals can also purchase insurance in the private market at high prices. Private health insurance is the closest thing we have to a mainstream of health care financing. This stream combines for-profit and not-for-profit insurers, and is extremely expensive to maintain; with administrative costs and profits for investors accounting for at least 31% of this private health care spending. Only 5% of homeless assistance users surveyed nationwide in 1996 were privately insured.

The Second Stream: Public Health Insurance. Recognizing the special vulnerabilities of indigent children, the elderly, and people with disabilities, the Congress has created a taxpayer-funded stream of health insurance — Medicare and Medicaid — to serve such people when they do not have private insurance. Historically, public health benefits have generally resembled those available through private insurance (though this is changing), but the overhead costs are substantially less. Some homeless people – 25% of HCH clients – participate in Medicaid and Medicare, and more are probably eligible but are not enrolled due to undocumented disabilities and unnecessarily complex enrollment systems. However, the vast majority of homeless adults are simply not eligible for Medicaid in most States, and are also not eligible for the Federal Medicare program.

A special category – Federally-financed health care for veterans of the armed services – must be considered part of the public stream. Unlike Medicare and Medicaid, veterans' health care is largely provided through a publicly-owned delivery system, the Department of Veterans Affairs (VA) hospitals. As in Medicaid and Medicare, eligibility for VA services is determined by an individual's status (as an honorably-discharged veteran, say, or as a disabled person). Although approximately 23 percent of surveyed homeless people are veterans of the armed services, only about 57 percent of those have received health care services through the VA system (1996 data).

Significantly, having public health insurance does not guarantee access to a health care provider. Declining numbers of providers will accept Medicaid or Medicare, and services are being restricted due to State fiscal weaknesses. With an estimated 500,000 veterans homeless at some time during the year, the VA reaches less than 20% of those in need, according to the National Coalition of Homeless Veterans.

The Third Stream: The Safety Net for the Uninsured. Today, 45 million Americans have no health insurance. While many go without care altogether; others use a third stream of health care resources — a set of free clinics, community health centers, hospital emergency rooms, public hospitals, and public health departments that are funded directly by governments, private charity, and charges to their patients. These facilities are traditionally thought of as the safety net for the uninsured, and their services are at least theoretically available without regard to ability to pay. However, the financial realities of inadequate grant income require even safety net providers to serve chiefly those who are insured or who can pay for services on a sliding scale.

A principal element of the Bush Administration's plans to increase access to health care appears to be the Health Center Growth Initiative, which would double the Health Center component of the safety net. Although primary health care of high quality can be obtained from health centers, services are woefully incomplete compared to what can be purchased with health insurance, with significant gaps in behavioral health care, specialty care, hospitalization and availability of pharmaceuticals.

The Fourth Stream: Health Care for the Homeless. The traditional safety net has not served homeless people well. Resource constraints, lack of experience in dealing with this population, and insufficient linkages to the full range of health and supportive services required to stabilize homeless people explain the inability of many providers to meet their needs. Safety net programs generally do not have outreach capacity, on-site multidisciplinary services such as addiction and mental health treatment, case management, food, clothing, showers, or employment assistance. Safety net programs may not have significant walk-in capacity (a necessary accommodation for homeless people) and may charge co-payments that are unaffordable for homeless individuals and families.

The Federal Health Care for the Homeless Program established by the McKinney Act was designed to overcome the shortcomings of the traditional safety net and has become, in effect, a fourth stream — the safety net below the safety net. Because so many HCH clients are uninsured, the financing for this stream is almost entirely grants from the Consolidated Health Center program, other government sources, and private funders.

Like other health centers, HCH is a primary care program with generally limited availability of specialty care and hospitalization, although HCH projects provide often sophisticated substance abuse treatment and mental health care. Accommodations to assure access to care are a hallmark of HCH projects, and the interdisciplinary team approach employed in HCH is a model of care worthy of replication throughout the health care system.

Because HCH is a component of the Consolidated Health Center program, the President's Growth Initiative is making funding available for new HCH projects and for expansions of existing projects. Regrettably, the new grant opportunities offer only $200 per client per year, far less than the actual cost of providing care.

Mainstreaming Health Care for Homeless People

In the thinking of some advocates, "mainstreaming" homeless health care services means increasing the accessibility of third-stream safety net services or even second-stream public health insurance for homeless people. While improvements in this regard would be important advances within the context of the current, fragmented, multi-stream health care financing system, homeless people would remain at the lower levels of a multi-tiered health care system where access to care depends on ability to pay.

The National Health Care for the Homeless Council holds that health care is a right, not a privilege of wealth or social status. All people are subject to the same ailments, and everyone should have the same access to care. The present complex system of health care financing, with multiple streams supporting varying levels of care, is inherently inequitable and cannot be made to adhere to the simple demands of health care justice.

The situation demands creation of a single system of health care financing, guaranteeing the same access to high quality, comprehensive health care for all. In the language of the current discussion of homelessness, there should be one main stream of health care, not several streams.

The Single Payer Solution

Happily, a major proposal for reform of health care financing has been published by the Physicians' Working Group for Single-Payer National Health Insurance (*Journal of the American Medical Association,* August 13, 2003). The proposal describes in significant detail a system modeled on the strengths of the Medicare program, in which the government provides the same health insurance for everyone (i.e., the government is the single payer) and the delivery system is entirely not-for-profit. Pending Federal legislation, HR 676, would enact this proposal.

The single payer approach to financing health care, long supported by the National Health Care for the Homeless Council, constitutes real mainstreaming of health care for homeless people, and merits the active attention and support of all those who are concerned about homelessness. The plan's universality, efficiency and just financing (through progressive taxation) benefit homeless people as well as everyone else, but three aspects are of particular note:

- Obviously, universal health insurance coverage will make health care a possibility for the large majority of homeless people who are not reached by *any* of the current streams of health care. Resolving individuals' health problems is essential to resolving their homelessness. This is particularly true for individuals whose chronic, disabling health conditions have contributed to their chronic homelessness.

- Universal health insurance coverage will be an important homelessness *prevention* measure. As the Institute of Medicine established, health problems actually cause homelessness. This occurs because untreated illnesses often result in job loss and financial ruin, because the cost of health care is a major contributor to personal bankruptcy, and because mental illnesses and addictive disorders are themselves risk factors for homelessness. Making preventive, primary, and specialty care available to everyone will dramatically undermine these factors, and reduce the incidence of homelessness.

- Even with universal coverage, people who are homeless will face certain access barriers. Although most care will continue to be provided by practitioners who bill the government on a fee-for-service or capitated basis, the single payer system will give agencies such as HCH projects sufficient institutional budgets to assure that accessible, comprehensive primary care services continue to be targeted to populations with special needs.

The full text of the proposal, a brief summary, and additional resources for supporting single payer health care may be accessed at www.nhchc.org.

We ardently urge all those who seek to end homelessness to actively support the growing movement for single payer national health insurance, the true mainstream solution.

National Health Care for the Homeless Council
Post Office Box 60427
Nashville TN 37206-0427

615/226-2292
council@nhchc.org
http://www.nhchc.org