



## The Price of Homelessness

George Kelly

*“My name is Eric and I currently live with Inner City Housing. I used to have very bad emphysema and needed to carry an oxygen tank wherever I went. Recently though I received a lung transplant. The doctors told me that one of the reasons they accepted me into the lung transplant program was because I live in a decent place that is clean and well maintained. I didn’t live in some rotten, run-down rooming house that is a health hazard. Inner City Housing charges rent that is affordable and that allows me to buy good food which is better for my health. The doctors at the hospital liked that, and they also liked my attitude about life and my willingness to take all the necessary steps like physical training to improve my health and stamina.”<sup>1</sup>*

At the Edmonton Inner City Housing Society where I work, we house hundreds of people, each of whom would have a story like Eric’s about their health or their family’s health and how it is improved by housing. The connection between homelessness, housing, and improved health is obvious to us.

What is obvious to us is also borne out by research. Any search of a Web browser, or review of the research, leads to this inescapable conclusion. Here are some examples:

- In 2001, the B.C. Ministry of Social Housing released a document reviewing the research on the relationship between homelessness and the health, social services, and criminal justice systems. Study

Failure to deal with a social problem “upstream” (lack of housing, education, health insurance, substance misuse prevention) leads to added costs for resources “downstream” (police, prisons, hospital care).

after study reviewed found that housing improves health and that homelessness deteriorates it.<sup>2</sup>

- A 2001 study of a supportive housing project in Nanaimo, B.C, found that there were far fewer hospital admissions for the residents (many of whom came from being homeless) for either medical or psychiatric reasons. The study also found that the average stay was cut in half for medical admissions and cut by 2/3 for psychiatric admissions.<sup>3</sup>

In the end, we all pay a higher price for people being homeless instead of housed.

“Failure to deal with a social problem “upstream” (lack of housing, education, health insurance, substance misuse prevention) leads to added costs for resources “downstream” (police, prisons, hospital care). The downstream institutions are not only expensive, but also poorly equipped to deal with the underlying social problems. Many people conclude, therefore, that preemptively attacking the problems upstream would be both more efficient and more effective, but the pattern stubbornly persists.

(continued on page 4)






## Director's Message

Kim Raine, PhD, RD

Health promotion is the process of enabling people to increase control over and to improve their health.<sup>1</sup> How much control does one have over one's health when denied access to one of the most fundamental prerequisites for health—shelter?

Interestingly, local research<sup>2</sup> reveals that homeless individuals listen to messages that promote self-care in attaining and maintaining health, and try to keep clean, eat well, and get adequate rest. They are, however, severely limited in their attempts by lack of income. With support, people like Charlene—who tells her story of resilience in this issue—can find ways to get out of homelessness and gain more control over their lives. But, as Pieter de Vos eloquently articulates, homelessness is a function of social inequities, not individual choice. Economic and social policies are primary determinants of poverty and inequity, and poverty and inequity are primary determinants of health. George Kelly emphasizes that current problems of homelessness can be linked to policy changes made a decade ago, the health impacts of which were likely never considered at the time, but have grave implications today.

As health promoters, we must enable ourselves to increase control over and to improve the social conditions that influence health. To do so, we cannot separate ourselves from the world of politics. The challenges of advocating for healthy public policy are huge, but not insurmountable.

We can learn from Charlene to be collectively resilient, even when faced with obstacles. 

## Social Inequities Compound Health Care Issues

Pieter de Vos, MSc (Population Health)

Since the 1980s, the poverty rate has grown in the United States, Britain, and Canada—a trend that corresponds to the shift away from Keynesian economic models towards a new fabric of relations between the state and civil society. This new fabric consists of neoliberalism in the form of deregulation, fiscal austerity, and the corporatization and privatization of the public sector.

The October 2002 homeless count in Edmonton identified 1912 individuals as being homeless. Forty-three percent (43%) were Aboriginal and 72% of the aboriginal individuals were observed to be absolutely homeless—that is, living on the street. Aboriginals are over-represented in the homeless population compared to the general population. They make up 43% of the street population but only represent about 4% of the total population of the city.<sup>1</sup>

The phenomena of homelessness and poverty are not new, and neither are the responses they generate. Typical reactions are to stigmatize poor people and to distinguish between those that are “deserving” or “undeserving” of societal support. The actions (and inactions) of governments at the federal, provincial, and municipal levels, have contributed to the problem.<sup>2</sup>

In an academic sense, homelessness illustrates how the individual can be subordinated to the body politic. Fundamentally, poverty is rooted in a system that promotes the well being of some members at the expense of others, and thereby reflects the inability of sectors of society to gain adequate access to essential resources. Far too frequently, this disparity is reflected at the individual level in the psychological and physical correlates of anomie and ill health. Homelessness predisposes individuals to a plethora of acute health problems and exacerbates chronic health conditions, leading to further deterioration of health status.<sup>3</sup>

While health is undoubtedly a complex issue—especially when it occurs in the context of poverty, addictions, and social marginalization—its multi-faceted nature is often a barrier to public policy. The medical problems of the homeless are numerous and reflect the lives they lead. These hardships tend to divert attention away from the simple policy solutions that need to be implemented. Examples include the provision and subsidy of affordable housing, the implementation of welfare rates that are tied to an “acceptable standard of living” and the adoption of a coherent framework to address the needs of the urban aboriginal population.

*(continued on page 4)*

Edmonton's homeless are not a homogenous group. They include families with children, youth, single men and women, seniors, and Aboriginals. They reflect equally diverse characteristics: mental illness, poverty, substance abuse, family breakdown, unemployment, lack of life skills. A combination of these factors often adds to the complexity.

— *Homelessness in Edmonton: A Call to Action*



## Finding My Way Out

Charlene

When I first came to the city, I was faced with the awful demon of racial prejudice. Everyday I would set out to find an apartment and, with so many buildings nearby, I felt that it shouldn't take me long. It took my (white) foster parents to advocate on my behalf so I could have a safe and healthy place to live.

During this time, I was partying on the weekend and I eventually went into the detox to get help. When I got out, I found an eviction notice underneath my door. My world around me was spiraling downwards because I was introduced to crack cocaine. Two eviction notices later, I gave up the idea of ever again having keys to open a door to my own dwelling. I felt worthless and it seemed there wasn't any easy way to help myself but to accept the realities of what my life had become.

During the winter, I managed to find temporary places I could stay at as long as I lived by their guidelines. Being a very independent person, this did not sit well with me. I felt trapped and used. Because I was still in my addiction with coke and alcohol, I stayed at the filthiest places because no one cared about the environment enough to think about diseases and dignity. This went on until the spring of 2003 and, as soon as the weather warmed up, I found a bush in a back alley that could serve the purpose of shelter.

I went there when I didn't have a place to go or just wanted to sleep. I was hurting inside and I felt powerless to cocaine. Out of respect for my family, I felt I couldn't go to them in my mental state. I knew there was the women's emergency shelter, but I didn't trust the other women. So, I stayed in my bush and the people who lived on the property didn't bother me. I felt like I wasn't judged and there was no one there to tell me to get out. Even the bumblebees I called Bee and Beatrice didn't seem to mind. A back alley cat would come around and poke his head in and wander on by. I felt so invisible.

After I surrendered and made the commitment to change, I stood up for myself and took the steps I needed to make in order to have a home. I stayed at a women's shelter. This gave me time to finish the day program at the Alberta Alcohol and Drug Abuse Commission (AADAC). I am now, once again, alcohol and drug free and have a place to call "home sweet home."

Charlene is a resident of the city of Edmonton.

## Homeless

*His feet are sticking out of a cardboard make-shift shelter to get away from the cold of the night.*

*She sits huddled over a cup of coffee in a cockroach infested cafe, Waiting for the warmth of the morning to come and keep her warm.*

*He is huddling against the cold wall with his breath in the air.*

*They have gotten into a boarded up house which helps to keep out the wind.*

*His body is shivering in the cold as he lies hidden in the parkade.*

*They wait for the doors to open so they can have a hot cup of coffee.*

*They are laying on a foam mat in the stinking garbage room.*

*He is laying on an old, filthy mattress hidden in the bushes along the riverbank.*

*You see them sitting on the cold concrete asking for a cigarette or some change.*

*They stand everyday in the long line waiting for soup and a bun.*

*Who are these people?*

*They are the homeless people that walk the streets, alleys and riverbanks of this city and many other cities.*

A poem by Betty Nordin, reprinted with her permission.

The reality of homeless people's lives is chilling. Studies\* confirm direct connections between homelessness and wide-ranging health and social problems. Compared to the general population, homeless people face higher rates of premature death, infectious disease, acute illness and chronic conditions and dental problems. They are prone to higher rates of injury and violence as well as depression, risk of suicide, mental illness and alcohol or substance abuse. Their situation is worsened by poor nutrition and hygiene. Homelessness also contributes to the development of treatment-resistant tuberculosis and other diseases such as Hepatitis C and HIV/AIDS.

— *Homelessness in Edmonton: A Call to Action*



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## Social Inequities Compound Health Care Issues

(continued from page 2)

It is tragic that a quarter of a century after the World Health Organization recognized that “the fundamental conditions and resources for health are peace, shelter, education, food, income, a stable ecosystem, sustainable resources, social justice and equity,” there has been a wholesale abandonment of these principles at the policy level.<sup>4</sup>

There needs to be the explicit recognition that social inequities constitute and compound health care issues. Typically, the intended impacts of policies aimed at reducing poverty and income inequality are economic and social. Health outcomes are not usually the target of these efforts. This arbitrary division between health care and socio-economic policy is a substantial barrier to the promotion of health, as Geoffrey Rose concludes:

“The primary determinants of disease are mainly economic and social, and therefore its remedies must also be economic and social. Medicine and politics cannot and should not be kept apart.”<sup>5</sup>

Pieter de Vos is a member of the Board of Directors of the Boyle McCauley Health Centre.

## The Price of Homelessness

(continued from page 1)

In the case at hand, we continue paying to put the homeless in hospital beds while not providing them with ordinary beds of their own.”<sup>4</sup>

Homelessness as a major issue in Canadian cities began in the mid- to late-1990s. Those of us in the housing community correlate the rise of homelessness to the decision of the federal government to end its housing programs in 1993. Very few provinces have picked up the challenge. The market cannot.

It is time the senior levels of governments returned to providing social housing programs. Homelessness will end when a continuum of housing is funded.

George Kelly is the Executive Director of the Edmonton Inner City Housing Society.

References related to articles printed in this issue are available on our Web site at [www.chps.ualberta.ca/publications/shift.htm](http://www.chps.ualberta.ca/publications/shift.htm).



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