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Navigating Health Inequities Among the Homeless Population through a Medical Anthropological Lens

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ABSTRACT

Using a medical anthropological lens, this review article examines the challenges that unhoused individuals with cancer face due to health inequities. We discuss the effects of delayed diagnoses on treatment and outcomes while considering cultural and societal factors influencing patients' health literacy and behaviors. The article evaluates the efficacy of current support systems in aiding disease detection and diagnosis. By identifying the needs and challenges of this vulnerable population, we propose policy recommendations that can address their unique circumstances. Ultimately, the objective of this article is to contribute to the development of comprehensive and inclusive healthcare policies that prioritize the overall well-being of homeless individuals facing disease, integrating perspectives from medical anthropology.

Introduction

Within the realm of public health, the issue of health inequity among homeless individuals remains an undeniable challenge.[1] Health inequities refer to avoidable and unjust differences in health outcomes, often rooted in systematic disparities known as social determinants of health. These determinants encompass conditions such as income, education, employment, access to healthcare, and living conditions. Notably, disadvantaged groups—including racial and ethnic minorities, low-income individuals, and marginalized communities—are impacted the most because of these inequities.[2]

Due to the absence of stable housing for homeless individuals, basic needs like food and shelter often overshadow the urgency to seek healthcare. This prioritization, which is sometimes misconceived as negligence or non-adherence, reflects individuals' fundamental fight for survival.[3] Furthermore, there exists a significant knowledge gap concerning cancer screening awareness and its utilization among the homeless population, underscoring the dire need for targeted health education and interventions.[4]

Anthropology, with its holistic grasp of human societies and cultures, offers invaluable insights into the unique challenges and needs of homeless individuals.[5] By adopting an anthropological lens, we can develop more tailored healthcare strategies that are both effective and compassionate. This literature review strives to shed insight into the health disparities experienced by homeless individuals and emphasizes the role of an anthropological lens in understanding and addressing these challenges.

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[1] https://www.who.int/health-topics/social-determinants-of-health#tab=tab_1

[2] https://www-clinicalkey-com.ezp-prod1.hul.harvard.edu/#!/content/book/3-s2.0-B9780323757898001894?scrollTo=%23hl0000234

[3] https://pubmed.ncbi.nlm.nih.gov/23663023/

[4] https://pubmed.ncbi.nlm.nih.gov/16255312/

[5] https://www.researchgate.net/publication/363143141_How_medical_anthropology_can_contribute_to_cancer_research

Health Disparities Among the Homeless

Social Determinants of Health

In a 2015 study conducted in Calgary, Alberta, Canada, researchers sought to qualitatively explore the healthcare needs and obstacles faced by homeless individuals.[6] They employed open-ended interviews and focus groups to engage diverse stakeholders involved in providing healthcare services to the homeless population in Calgary. Through this investigation, the study unveiled crucial social and cultural factors that hinder homeless individuals from attaining their best possible health.

One prominent issue that emerged throughout the study was the overwhelming presence of stress in the lives of homeless individuals. In one interview, a healthcare worker highlighted this issue: "They're already in a stressful situation in their life being homeless. The stress level is incredible so to throw in a health issue would just increase that stress more than they can possibly bear without support. They might be scared to go to the doctor in case something that they can't handle arises. Lack of social support could also mean they feel like they have no one to lean on if they do get bad news…"

Another significant obstacle highlighted in the study is the hierarchical nature of medical systems. One healthcare provider remarked, "Most of our people [homeless individuals] have a fear of authority. Medical systems are structured to represent that. They're incredibly hierarchical and even physically they're set up to be daunting to get through… a lot of our clients will hide ailments and I think that just comes from a lifetime of fear of authority."

Moreover, the study revealed that homeless individuals commonly grapple with feelings of shame, low self-esteem, and worthlessness. A homeless male individual pointed out the psychological barrier associated with identifying oneself as homeless when seeking medical care. He expressed that part of this discomfort stems from one's own shame in identifying as homeless, while the other part is due to negative stereotypes perpetuated by the medical community. Furthermore, healthcare providers' assumptions and tendency to fit homeless individuals into a single stereotype, often legitimized by societal norms and common misconceptions, such as associating homelessness with criminality or laziness, can result in ineffective care, miscommunication, and a breakdown of trust between the provider and the patient, further marginalizing this population.[7] In addition, homeless individuals with mental illnesses face heightened levels of stigma, which often lead them to seek emergency services when their health deteriorates to a critical point, further isolating themselves from society.[8]

Practical challenges such as a lack of transportation can be unnoticed during patient discharge, leading to distressing situations. A homeless individual recounted a peer's difficulty in being discharged from the hospital with no means of transportation or support, forcing him to walk to his shelter.[9] Furthermore, maintaining continuity in healthcare becomes incredibly daunting when dealing with the challenges of securing basic needs like transportation, food, or shelter.[10]

Lastly, the lack of financial resources significantly contributes to the many challenges that the homeless population experiences. In a 2017 study that presented three case histories of homeless patients from an inner city public hospital in Perth, Western Australia, the intertwined nature between social disadvantage and health was shown[11]:

[6] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4603688/
[7] https://unityparenting.org/why-homelessness-is-stigmatized/
[8] https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0229385
[9] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4603688/
[10] https://store.samhsa.gov/sites/default/files/pep20-06-04-003.pdf
[11] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5750953/

- A 35-year-old indigenous man who had been homeless for ten years often slept on the streets. He experienced severe injuries from two car accidents in his early twenties and became wheelchair-bound by 2013 due to the injuries and multiple leg fractures. He abused solvents and alcohol during his teenage years leading to physical and intellectual impairment. Despite being approved for permanent supported care, he always returned to the streets. In 27 months, he had 51 emergency room visits costing $33,456 and 28 inpatient admissions costing $299,460, totaling nearly $333,000.
- A 58-year-old non-indigenous man had been homeless since his early thirties and lived under a bridge for 26 years. He developed schizophrenia and, over the years, had other health complications due to his heavy smoking and alcohol consumption habits. By late 2016, he became wheelchair-bound due to severe lumbar spine disease. Over 29 months, he had 69 emergency room visits costing $45,264 and $202,860 for 84 hospital bed days.
- A 31-year-old non-indigenous woman, estranged from her family and partner, became homeless for 18 months due to heavy alcohol use and an eating disorder. She faced regular assaults while living on the streets and faced barriers to finding stable accommodation due to her heavy alcohol intake. She expressed a need for stable accommodation and a steady income. Over 27 months, she accumulated costs of nearly $623,000, including psychiatric and medical admissions.

These stories underscore the highly personal and unique aspects of experiencing homelessness and emphasize the need to address the various factors contributing to health disparities. In addition, the three case histories illustrate the complex web of social determinants at play in the lives of homeless individuals, humanizing the issue and highlighting its prevalence. These challenges underscore the urgent need for a healthcare approach that is not only more compassionate but also tailored specifically to the needs of homeless individuals.

Among the homeless population, the social determinants of health often stem from early life adversities and trauma. These experiences can lead to poor education, disengagement, substance abuse, unstable relationships, erratic work history, and incarceration.[12] The accumulation of these challenges, coupled with the absence of a stable support system, can result in homelessness.[13][14] These individuals' experiences are not mere data points to be analyzed but complex realities that require targeted solutions for addressing health disparities.

Health Literacy

The definition of health literacy developed by the National Library of Medicine and used by *Healthy People 2010* is the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions.[15] The definition goes beyond the mere act of reading health-related material, stressing the need for an extensive understanding and practical application of such information.

A 2006 study conducted in central North Carolina, examining medication barriers among homeless women, revealed that those with low health literacy faced greater challenges in administering medication to their children compared to those with higher health literacy.[16] This finding underscores the significant impact

[12] Baldry, Eileen, et al. "Lifecourse institutional costs of homelessness for vulnerable groups." *National Homelessness Research Agenda* (2012): 1-121.

[13] Fitzpatrick, Suzanne, Glen Bramley, and Sarah Johnsen. "Pathways into multiple exclusion homelessness in seven UK cities." *Urban Studies* 50.1 (2013): 148-168.

[14] Baldry, Eileen, et al. "Lifecourse institutional costs of homelessness for vulnerable groups." *National Homelessness Research Agenda* (2012): 1-121.

[15] https://www.ncbi.nlm.nih.gov/books/NBK216035/

[16] https://pubmed.ncbi.nlm.nih.gov/16452520/

of low health literacy, extending beyond individual consequences to affect the health and well-being of family members, particularly children.

In addition, an examination of health literacy levels among street sex workers who were either homeless or marginally housed suggested that all participants (of a small sample) had health literacy levels below the high school reading level.[17] These findings can lead to difficulties in navigating the complex healthcare system.

A 2019 study conducted in Oklahoma City explored the relationship between health literacy and self-rated health among homeless adults (reference). After adjusting for various factors such as age, education, race, sex, income, and high blood pressure, the results showed that individuals with higher health literacy were more likely to report better self-rated health, indicating a significant connection between health literacy and well-being among the homeless population. This finding underscores the potential impact of health literacy on shaping the health outcomes of homeless individuals.[18]

Regarding cancer, misconceptions held by homeless women include the belief that cancer inevitably leads to death, that larger breasts have a higher risk, and that trauma can cause cancer.[19] Such misconceptions further highlight the pressing need for improved health education and outreach.

The intricate web of health disparities and challenges faced by homeless individuals, as highlighted by the concept of health literacy, is a pressing issue that calls for a multifaceted approach. An anthropological lens helps develop tailored interventions, improve health education, reduce stigma, and enhance well-being. This holistic approach, blending medical anthropology and healthcare, is essential for closing the healthcare gap for homeless individuals.

Delayed Diagnoses

Delayed diagnoses can lead to poor treatment outcomes, and homelessness introduces unique challenges within the healthcare system that can lead to such delays. In this context, it is essential to explore how homelessness impacts healthcare timelines and patient choices.

In a study from an academic county hospital in Seattle, Washington, medical records from 2012 to 2018 were reviewed of 133 non-small-cell lung cancer (NSCLC) patients, including 22 (17%) who were homeless during treatment. Homeless NSCLC patients with localized cancer experienced a longer delay in obtaining biopsies after radiographic findings were reported (248 days vs. 116 days for housed patients). They also missed more appointments post-diagnosis (26% vs. 16%), and homeless patients with advanced NSCLC had shorter median survival (0.58 years vs. 1.30 years for housed patients).

The study also revealed that homeless patients with localized lung cancer lost contact with the medical team (i.e., lost to follow-up, moved out of the area, or transitioned to hospice) at twice the rate of housed patients, leading to poorer outcomes. Moreover, the transient nature of homelessness raised concerns about follow-up care. All housed patients completed therapy, while two of the nine homeless patients could not. The reason for this disparity is suggested by the nearly doubled rate of missed appointments by homeless patients compared with housed patients.[20]

[17] https://www.researchgate.net/publication/338055346_Examining_Health_Literacy_Levels_in_Homeless_Persons_and_Vulnerably_Housed_Persons_with_Mental_Health_Disorders
[18] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8218643/
[19] https://pubmed.ncbi.nlm.nih.gov/8577623/
[20] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7489482/

High Rates of Death

This section examines the direct link between homelessness and mortality rates. While basic conditions like common illnesses and inadequate nutrition may seem benign, they can rapidly escalate into life-threatening issues, as supported by recent research findings.[21]

One retrospective analysis was based on data from 615 homeless individuals, of whom 176 died in the analyzed period of 2010-2016 (reference). Of most concern was that the average lifespan of a homeless individual was reduced by approximately 17.5 years compared to the general population. This stark disparity underscores the gravity of the health challenges faced by those without stable housing. Furthermore, homeless males have an average age at death of 56 years, while homeless females have an average age at death of just 52 years. Most deaths occurred in conditions of cold stress, particularly from hypothermia. Deaths from hypothermia occurred thirteen times more frequently among the homeless population compared to the general population.[22]

Given these alarming statistics, intervention is ethically imperative. Addressing the healthcare needs of homeless populations is a complex and urgent task, with human lives at stake. Homeless individuals face multiple challenges such as fear of authority, feelings of shame, and a lack of transportation and financial resources when accessing or attempting to access healthcare. Furthermore, low health literacy which can lead to delayed diagnosis, ultimately increasing mortality rates, underscores the need for realistic, applicable solutions using an anthropological lens. The solution lies in the provision of comprehensive basic healthcare services and stable housing as the first step.

Applying an Anthropological Lens

Medical anthropology, a subfield of anthropology, offers a way to understand how diverse global populations perceive and experience illness. This field particularly emphasizes research methods that humanize our understanding of diseases in varied settings, offering valuable insights into diseases like cancer.[23] The role of anthropology in healthcare, especially in low and middle-income communities, is crucial in understanding local realities and real-life experiences that can improve cancer control.[24]

In an interview, Cynthia, a breast cancer survivor, and Kirk, a health educator with experience in homeless nonprofits, discussed potential interventions for homeless individuals with cancer.[25] Cynthia suggested adapting existing programs, like food banks, to provide specialized groceries for cancer patients undergoing chemotherapy who cannot eat the same types of food. She emphasized the willingness of cancer survivors to help homeless individuals navigate the healthcare system. In addition, Cynthia highlighted Dr. Stephan Kertesz's advocacy for respite centers for homeless cancer patients. She stressed the need for funding to establish these centers.

[21] https://nhchc.org/wp-content/uploads/2019/08/homelessness-and-health.pdf
[22]https://pubmed.ncbi.nlm.nih.gov/29267330/
[23]https://www.researchgate.net/publication/363143141_How_medical_anthropology_can_contribute_to_cancer_research
[24] http://www.cancercontrol.info/wp-content/uploads/2020/11/71-Caduff.pdf
[25] https://www.aacr.org/patients-caregivers/patient-advocacy/education-inspiration/dialogues/dialogue-advocates-reach-out-to-a-neglected-community/

Effective Interventions

To address the issue of delayed access to crucial benefits and services for homeless individuals in the healthcare sector, communities can establish priority access mechanisms. For instance, in Norfolk, Virginia, the Ryan White funding program allows participants in the Permanent Supportive Housing (PSH) initiative at the Norfolk AIDS Care Center for Education and Support Services to bypass waiting lists for mental health services provided by the Norfolk Community Service Board (reference). Similarly, Denver's Road Home (DRH), a key organizing entity within the Denver mayor's office responsible for addressing homelessness as part of its "10-Year Plan to End Homelessness," uses a lottery system to prioritize homeless applicants for Section 8 Housing (reference). This federal program assists low-income families, individuals with disabilities, and the elderly in affording housing, resulting in improvements in access rates and reduced wait times.[26] This successful intervention underscores the vital role of an anthropological lens in addressing health disparities and emphasizes the urgency of prioritizing the health of marginalized individuals.

Mobile clinics, as well as the establishment of temporary clinics within homeless drop-in centers and shelters, effectively address access barriers and allow healthcare providers to establish trust and connect with many underserved individuals. However, for a significant minority who remain hard to reach, Health Care for the Homeless (HCH) projects deploy outreach workers who play a crucial role in locating homeless individuals, building trust and rapport with them, and encouraging them to take care of themselves and ideally seek medical assistance (reference). Locating those in need often involves visiting abandoned buildings, areas under bridges, street benches, parks, and various improvised living spaces. Successful outreach necessitates an understanding of street culture, effective communication methods, and the delicate balance of engagement without alienation.[27]

To enhance the continuity of healthcare for clients lacking permanent housing, tracking systems have been developed to monitor the various places each person visits regularly. This system allows outreach workers to find individuals when necessary.[28] In cases where homeless individuals with urgent healthcare needs remain reluctant to seek services, healthcare professionals could join outreach workers. For instance, HCH clinicians in Boston, Massachusetts, established a training program and manual to guide this collaborative approach.[29][30][31]

Medical respite care services have been established as a part of HCH projects to address another gap in healthcare: a need for medical care for homeless individuals who are too unwell to recuperate from physical illnesses or injuries while living on the streets but do not require hospitalization. Although two medical respite facilities initially emerged in the mid-1980s to bridge this gap, a series of factors, including budget cuts from

[26] https://www.benefits.gov/news/article/388

[27] Blankertz, L. E., Cnaan, R. A., White, K., Fox, J., & Messinger, K. (1990). Outreach efforts with dually diagnosed homeless persons. *Families in Society*, *71*(7), 387-397.

[28] Nichols, J., Wright, L. K., & Murphy, J. F. (1986). A proposal for tracking health care for the homeless. *Journal of community health*, *11*(3), 204–209. https://doi.org/10.1007/BF01338801

[29] Levy, B. D., & O'Connell, J. J. (2004). Health care for homeless persons. *New England Journal of Medicine*, *350*(23), 2329-2332.

[30] O'Connell, J. J., Oppenheimer, S. C., Judge, C. M., Taube, R. L., Blanchfield, B. B., Swain, S. E., & Koh, H. K. (2010). The Boston Health Care for the Homeless Program: a public health framework. *American Journal of Public Health*, *100*(8), 1400-1408.

[31] Swain, S. E., Daniels, C. L., & Allen, J. S. (2004). *The health care of homeless persons: a manual of communicable diseases & common problems in shelters & on the streets*. Homeless.

hospitals throughout the 1990s, created challenges for many communities in meeting this escalating demand for services.[32]

HCH programs creatively use existing community resources, offering various facilities from shelter-based beds with visiting clinicians to standalone centers. In 2012, 73 facilities in 28 states were listed, with research showing positive user outcomes despite limited availability.[3334]

Furthermore, the Patient Protection and Affordable Care Act of 2010 is the most significant expansion of the U.S. healthcare system since Medicare and Medicaid in the 1960s. It was expected to reduce the rate of uninsured individuals by half; however, homelessness presents multiple access barriers beyond insurance, requiring ongoing attention from models like HCH.[35] Importantly, acts that promote a more equitable healthcare system recognize that health disparities are not solely a result of individual choices but are often a result of systemic factors.

The issue of "patient dumping," or homeless patient discharges without proper planning, was addressed by California's Senate Bill 1152 in 2018.[36] This bill mandates hospitals to establish an extensive discharge planning policy for homeless patients. This policy must involve coordination with various agencies, including healthcare and social services agencies, healthcare providers, and nonprofit social service providers whenever possible.[37] This legislation requires that hospitals provide meals, transportation, and clothing to homeless patients, in addition to documentation of discharge to a safe location.[38] While well-intentioned, this legislation does not fully address the fundamental issue faced by homeless patients: the absence of reliable resources and a secure environment for their recovery.[39]

The solution to health disparities among homeless individuals lies in housing. The Housing First Initiative, introduced in 1988, prioritizes providing permanent housing to homeless individuals without prerequisites or mandatory programs.[40] This program significantly improves health outcomes, reduces healthcare costs and Medicaid expenses, and leads to a decrease in homelessness, while also reducing substance use among participants.

Interventions to improve health literacy among homeless individuals are crucial for enhancing their self-rated health. Shelters and homeless-serving agencies can facilitate this by offering classes and navigation services that focus on practical health literacy skills. These interventions should include materials with lower reading levels to make them more accessible and engaging.[41]

Moreover, a study aimed at evaluating a community-based intervention that encouraged screening mammography among disadvantaged women using an inner-city drop-in center in Toronto, Canada, found that the rate of women receiving annual mammograms increased by 29.2%. The success of this intervention can be

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[32] Zerger, S., Doblin, B., & Thompson, L. (2009). Medical respite care for homeless people: a growing national phenomenon. *Journal of Health Care for the Poor and Underserved*, *20*(1), 36-41.

[33] National Health Care for the Homeless Council. Medical Respite: What is Medical Respite Care? 2012. Available at: http://www.nhchc.org/resources/clinical/medical-respite.

[34] Doran, K. M., Ragins, K. T., Gross, C. P., & Zerger, S. (2013). Medical respite programs for homeless patients: a systematic review. *Journal of health care for the poor and underserved*, *24*(2), 499-524.

[35] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3969140/

[36] https://www.beckershospitalreview.com/quality/california-law-to-regulate-homeless-patient-discharges-5-things-to-know.html

[37] https://calhospital.org/wp-content/uploads/2019/01/afl-19-01.pdf

[38] https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=201720180SB1152

[39] https://journals.lww.com/em-news/Fulltext/2019/03000/News__California_Law_Setting_Discharge_Rules_for.1.aspx

[40] https://onlinelibrary.wiley.com/doi/abs/10.1002/casp.723

[41] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8218643/

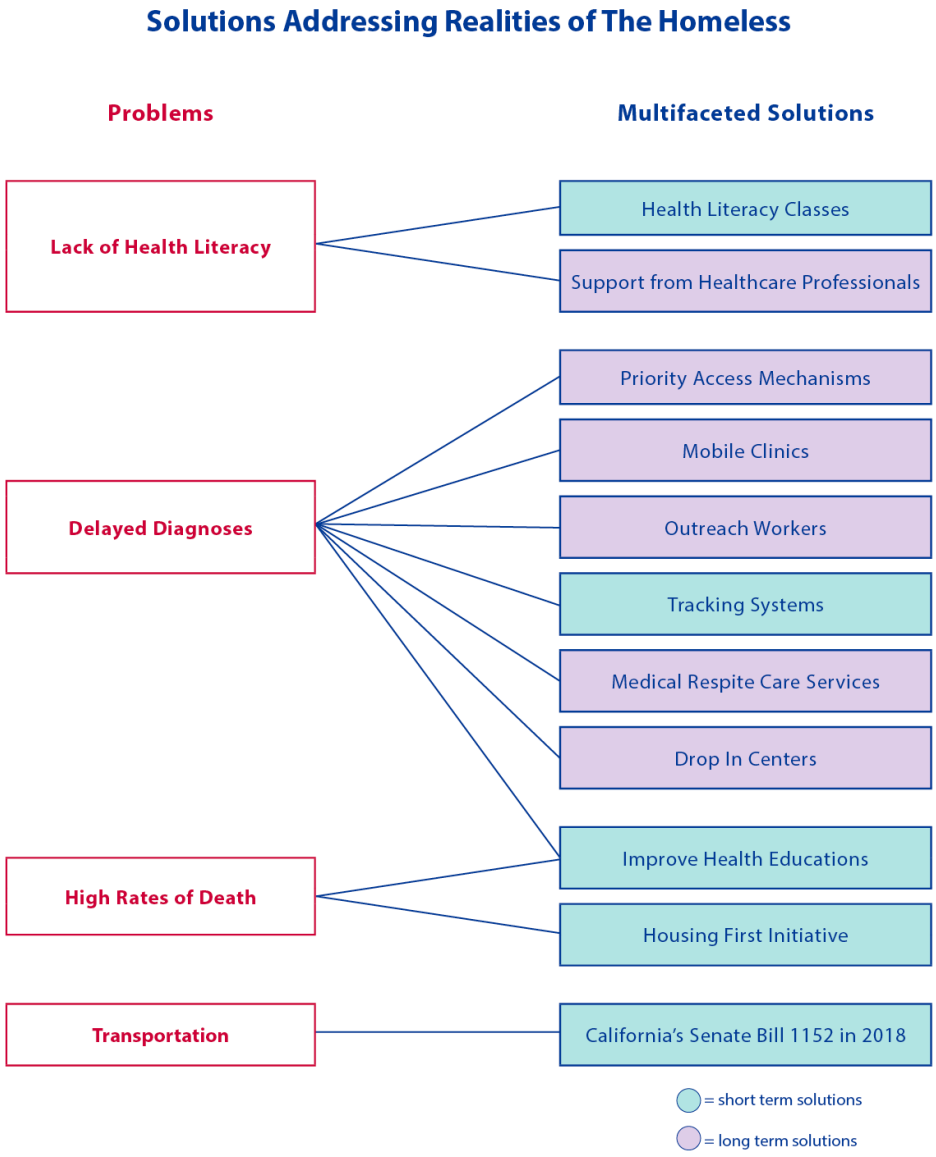
attributed to the trust between clients and drop-in center staff, the flexibility of the mammography center in scheduling group appointments, and staff accompaniment to mammography visits.[42] The strategy of conducting accompanied small-group visits was successful in encouraging breast cancer screening among individuals experiencing homelessness or mental illness.

To effectively address the diverse health disparities homeless individuals face, a multifaceted approach that includes priority access mechanisms, mobile and outreach clinics, innovative tracking systems, medical respite care, and legislative measures like California's Senate Bill 1152 is needed. However, it is critical to recognize that housing is the key to improving health outcomes, and initiatives like the Housing First programs embody this. In addition, promoting and implementing health education can help empower homeless individuals to make decisions about their health.

Conclusion

Effective healthcare depends on cultural competence, which emphasizes clear communication between caregivers and patients to bridge cultural differences that may hinder proper care. In addition, diverse healthcare teams and anthropological insights are vital for equitable care, particularly in addressing health disparities faced by the homeless. This anthropology-informed approach promotes a holistic approach to healthcare by highlighting the connections between culture, health, and individual experiences. By considering cultural aspects, healthcare professionals can build trust and understanding with patients. Healthcare must embrace cultural sensitivity for patient-focused care, making it a crucial element for a healthier and more inclusive future.

[42] A community-based intervention to increase screening mammography among disadvantaged women at an inner-city drop-in center. Heyding, Robert K



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