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Editorials and Annotations

Editorial: It's Time for the Public Health Community to Declare War on Homelessness

A decade ago, Congress enacted the Stewart B. McKinney Homeless Assistance Act (Pub L No. 100-77). Legislators and advocates for the poor and homeless fought long and hard to get this legislation passed and subsequently reauthorized and funded from year to year. The McKinney Act has provided health care, mental health care, food assistance, emergency shelter, transitional housing, and facility construction. It also established the Interagency Council on the Homeless to coordinate the activities of federal agencies, and in subsequent reauthorizations, additional programs were designed to help persons with acquired immune deficiency syndrome (AIDS), women in domestic violence shelters, and children in homeless families. Research demonstration projects have been funded to develop better models of serving the needs of homeless people, one of which is described in this issue of the Journal.[1] The McKinney Act has alleviated distress for untold numbers of people on the streets and in the shelters of American cities. Billions of dollars have been appropriated by Congress.[2] Thousands of workers, often underpaid and impelled by humanitarian motives, have brought help and healing to our most disadvantaged fellow citizens.

The McKinney Act, however, was intended only as a first step towards addressing the problems of homelessness in America: more far-reaching responses were to follow, but have yet to occur. We find, therefore, in 1997, that although immense effort has gone into developing services for homeless people in almost every city across the country, and in spite of all that has been achieved in addressing the needs of homeless people, there is no evidence that the extent of homelessness in America is less than it was a decade ago, that the problems of homeless people are less severe, or that their health status has improved. Some would say the problem is worse, and many predict that with the welfare reforms of 1996, the numbers of homeless people will increase.

The relationship between homelessness and health has been clearly demonstrated in numerous studies over the past decade. Homelessness is injurious to people's health and the situations in which homeless people are often compelled to live may be as hazardous to their health as the streets themselves. Homeless people are at increased risk for tuberculosis and other respiratory diseases, trauma, major mental illnesses, alcoholism and its sequelae, drug abuse and dependence, sexually transmitted diseases, and a host of other relatively minor, but nonetheless impairing, respiratory, dermatological, vascular, nutritional, and psychiatric disorders. What is more, the sick and disabled are often those who become homeless.[3] Homelessness should be recognized as a major public health concern. We should be as much concerned about the thousands of people who are homeless in American cities and the thousands of children in residentially unstable families as we are when there is an epidemic of an infectious disease affecting a few hundred people, and we should respond with the same urgency. In general, however, the public health establishment has been on the sidelines in the ongoing struggle for the availability and accessibility of ad-

Editor's Note. See related articles by Susser et al. (p 256), Bassuk et al. (p 241), Herman et al. (p 249), Zima et al. (p 236), Greene et al. (p 229), and Robertson et al. (p 221) in this issue.

equate housing for all Americans. Admittedly this Journal has been a principal publisher of research on homelessness and health, and a small group of committed individuals has constituted a Caucus on Homelessness within the American Public Health Association, but in general, the public health establishment has not seen the elimination of homelessness as a public health priority.

In the 1980s, when professional and public concern about homelessness was at its peak, a new field of inquiry was born (or reinvented)—homelessness research. A Medline computer search indicates that the annual number of citations combining "health" and "homelessness," essentially zero up until 1984, increased to 70 per year by 1990, after which the numbers remained fairly constant.[4] The characteristics of homeless people as a whole are now well documented, and the focus of research has shifted to, for instance, special subgroups of homeless people, the dynamics of homelessness, risk factors, effective strategies for intervention, and prevention. Methodologically, the field has become more sophisticated. This issue of the Journal is welcome because it includes contributions from several of the nation's foremost researchers in homelessness, who demonstrate how the field has advanced from description to analysis and how our concept of homelessness has progressed so that instead of thinking of it as a state we understand it as a process.

Homelessness is not as rare as most of us would like to believe. Counting homeless people is notoriously difficult, but the most recent estimate, based on a nationwide US sample, suggests that as many as 7.4% of the population (13.5 million people) may have experienced homelessness at some time in their lives.[5] A decade of research has shown, also, that homelessness is more complex than most people realized. There is seldom a single reason that a person, or a family, becomes homeless. There is an array of individual factors that increase vulnerability: illness, disability, substance abuse, domestic violence, disaffiliation, or job loss. Another array of structural problems within the society creates the conditions that place people at risk: housing shortages, deinstitutionalization policies, changes in the industrial economy, failed educational systems, racism, inadequate income supports.[6] In any individual case, several factors are likely to be operative.

We have learned, too, not to think of homeless people as an underclass, "the homeless." We have gotten away from the misconception of viewing them as a class of individuals characterized by the single attribute of being homeless, and typified by the minority who are street dwellers, huddled in doorways and in bus stations or in squalid welfare hotels. In fact, the homeless population is made up of many types of people, and not all homeless people share the same experiences. There is a continuum of residential stability. Some have transient episodes of homelessness and health profiles that may be little different from those of other people in poverty. Others exhibit cyclical patterns in and out of permanent housing. The least fortunate few spend long periods as street dwellers and are at greatest risk of physical illness, addictions, and mental disability.[7] The six papers in this Journal present findings relating to six distinctly different study populations: homeless families in shelters in Massachusetts,[8] citizens all across the United States,[9] mentally ill men in New York City,[1] children in family shelters in Los Angeles,[10] runaway youths in three national samples[11] and homeless adults in a suburban California county.[12] All share common characteristics—poverty and the lack of adequate permanent shelter. Beyond that, whether they have anything in common, other than their homelessness, is not clear.

Research is now also providing better understanding of the processes that lead to homelessness and the ways in which people get out of it. Significant predictors for homelessness in adult life include events and circumstances as far back as childhood, such as physical abuse, parental absence, residential instability, or placement in foster care. The homelessness of a mentally ill man may have its roots in his childhood home. Prospectively, also, the way the same homeless man is treated now will affect the likelihood of his becoming homeless again 2 years later.[1]

A way of ending homelessness, or even reducing it, has still to be found. Building more shelters will not do it; reversing deinstitutionalization policies or putting more assertive community mental health teams on the streets will not do it either. Cutting back on welfare entitlements will certainly not do it. Even improving the welfare system will not solve the problem. In Denmark, where the social safety net is very robust compared with ours, there still are homeless people.[13] What is needed is the political will to make the necessary resources available for a series of major reforms.

The problem is fundamental. The persisting spectacle of homeless people on American streets is a continuing indictment of our collective failure to make the basic ingredients of civilized society accessible to all citizens. Whatever individual vulnerabilities may exist, research continues to show that homelessness is rooted in deficiencies in these basic ingredients: the availability of adequate housing for all citizens, the opportunity to earn a reasonable income, education to fit people to be productive in the modern economy, safe communities, a supportive and stable childhood environment, and health promotion, treatment, and rehabilitation for everyone.

Public health professionals can be powerful advocates for change. The rejection of extreme conservative policies in 1995 and 1996 demonstrated that Americans, while always concerned about their individual security, nonetheless believe in protecting the common good. Public health has provided effective leadership in other struggles: implementing preventive health services, improving the environment, defeating the tobacco industry, controlling the availability of firearms, pressing for universal access to health care and defending a woman's right to choose. Public health must now proclaim to the nation that homelessness, a major affront to our notion of ourselves as a civilized society, is also a major health issue.

Public health advocates should press for the problem to be attacked from both the individual and the structural vantage points. Methods must be developed, based on risk-factor research such as is reported in this issue of the Journal, to identify individuals at special risk of homelessness and implement preventive interventions. But, in addition, it must be asserted that housing, income support, education and employment are fundamental requirements for healthy lives. Political resources must be mobilized to address these issues just as vigorously as they have in the past campaigned for good nutrition, clean water, and eradication of epidemic diseases.

Perhaps the lack of action from public health advocates in this sphere arises from a sense of futility: there is no simple, easily implemented solution; the factors seem too complex; the philosophy of the day emphasizes personal responsibility over community responsibility. But

public health agencies and professionals have taken on other complex health issues facing the nation—defeating AIDS and the war on drugs, for example. In the past, public health professionals have ventured into areas that seemed far from their area of expertise: engineering water supplies, toxic waste disposal, advertising, food-handling technology. Why should they not be involved in other issues that have an important bearing on health? Why do we not debate or investigate methods for providing low-cost housing, the structuring of housing subsidies, or policies and procedures for evictions—as health issues? Why do public agencies, such as the Centers for Disease Control and Prevention, not routinely monitor data on the morbidity and mortality associated with homelessness? Why, when we advocate deinstitutionalization, have we not compelled states to construct new housing to replace the mental institutions they are closing? Why are vocational training and employment not seen as health issues as much as economic issues?

The war on homelessness must be fought, as a public health issue, on many fronts. There is no place for defeatism. Homelessness in America should be eradicated. □

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Annotation: Hypertension in Populations of African Origin

Interest in the prevalence of hypertension and its consequences in peoples of African origin goes back a long way. The early focus was on the apparent absence of hypertension in subjects in Africa.[1] Later, the focus shifted to the United States, with interest and concern centered on the high rates of hypertension among people of African origin compared with White subjects.[2] In the early 1960s, awareness grew among those working in the field of hypertension that sharing of information was essential to progress. An international symposium on the epidemiology of hypertension was held in Chicago in 1964, the proceedings of which remain an important source of relevant data.[3] The Chicago-based study of hypertension prevalence in seven populations of African origin reported in this issue of the Journal is firmly rooted in the ethos of that meeting.[4]

Many Black–White comparisons have clearly demonstrated marked blood pressure differences between the two groups. However, researchers have been unable to discriminate between the many differing environmental factors between the racial groups, nor have they had the means of assessing the genetic contribution. The examination of blood pressure levels in populations of Black subjects of similar genetic origin living in a wide range of different environments offers an approach to breaking the deadlock. Given the circumstances, the methodological achievements of the present study are remarkable. There can be little argument that as one moves from West Africa to the Caribbean and to the United States, the prevalence of hypertension increases progressively. Mean blood pressures were similar among persons aged 25 to 34 years, but thereafter the prevalence of hypertension rose twice as steeply in the United States as in Africa. Body mass index and the urinary sodium-potassium ratio varied consistently with disease prevalence across the regions and could be the main determinants of the increase in hypertension prevalence with age. There has long been evidence that rising blood pressure is not a necessary accompaniment of the aging process.[5,6] The present study adds to the belief that the rise of blood pressure and the increase in prevalence of hypertension with age are environmentally determined.

What of race and genetics? Early studies in South Carolina proposed that African Americans responded to environmental factors in a genetically determined fashion, with the genetic factors predominating.[7] Then followed the theory of selective survival, which proposes that selective mortality during migration under the severely adverse conditions of the "middle passage" left a surviving genetic stock that differed from the genetic stock of those who remained in Africa. There appears to be little evidence for such a hypothesis, and there have been several strong rebuttals of the proposition.[8–10] By comparing geographic samples of groups sharing a common genetic background, this study has reproduced the pattern that might have been expected as a result of the historical migration. The data demonstrate the development of hypertension with transition from a rural economy to an

Editor's Note. See related article by Cooper et al. (p 160) in this issue.