



Urban Homelessness and Poverty During Economic Prosperity and Welfare Reform: Changes in Self-Reported Comorbidities, Insurance, and Sources for Usual Care, 1995–1997

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ABSTRACT *Little is known of how homeless and other urban poor populations have fared during the robust economy and within structural changes in health care delivery and entitlement programs of the 1990s. This is important in determining the need for population-specific services during a vigorous economy with low unemployment and increasing Medicaid managed-care penetration. This study compared health insurance status and availability of a source for usual medical care, psychiatric and substance abuse comorbidities, and perceived causes of homelessness in homeless adults surveyed in 1995 and 1997. Cross-sectional, community-based surveys were conducted in 1995 and 1997 at sites frequented by urban homeless adults residing in Pittsburgh, Pennsylvania. Self-reported medical, mental health, and substance abuse comorbidities, health insurance, and source for usual care were measured. Compared to the 388 individuals surveyed in 1995, the 267 homeless adults surveyed in 1997 had more medical comorbidity (56.6% vs. 30.2%, $P < .001$) and mental health comorbidity (44.9% vs. 36.9%, $P = .04$) and required more chronic medication (52.1% vs. 30.3%, $P < .001$). More respondents in 1997 than 1995 reported having no health insurance (41.4% vs. 29.4%, $P < .001$). While there was no difference in the overall proportion reporting a source for usual care (78.3% in 1997 vs. 80.2% in 1995, $P = .55$), fewer persons reported use of the emergency department and more persons reported using a shelter-based clinic for usual care in 1997 compared with 1995. These findings suggest more need for medical care among homeless and urban poor persons in 1997 compared with 1995 and support the continued need for outreach and support services despite a vigorous economy.*

KEYWORDS *Health Access, Homeless, Medicaid Managed Care, Welfare Reform.*

INTRODUCTION

While homelessness has been present throughout the 20th century, in the latter part of the 1990s there has been less attention focused on this subject.¹ This fall from

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public consciousness comes at a time of record economic growth and national prosperity and with the passage of federal and state welfare reform initiatives that have dramatically reduced the number of persons receiving federal and state entitlements. While the benefits of a robust economy have been described in aggregate terms, less is known about those individuals who represent the most destitute segments of society and how they have fared during this time.

This trend of economic growth and welfare reform has also been seen in Pittsburgh, Pennsylvania. During the period from 1995 to 1997, the unemployment rate of the greater Pittsburgh region was between 4.9% and 5.9%, comparable to the national unemployment rate (4.9%–5.6%) and much lower than that experienced in the early 1980s (1982–1984 rate was 11.4%–13.8%).² In 1996, the Pennsylvania legislature passed a series of welfare reform measures that included changing the state eligibility requirements for medically needy adults who had been receiving medical and general assistance, the replacement of Aid to Families with Dependent Children (AFDC) with a phased-in, time-limited Temporary Aid to Needy Families (TANF), and HealthChoices legislation that shifted Medicaid coverage to managed-care organizations (MCOs).³ This legislation was expected to have an impact on 260,000 adults in Pennsylvania.⁴

The role of entitlements and other social services on health and access to health care have been reported in earlier studies. Previous work has demonstrated the adverse impact that loss of health insurance can have on a population.⁵ A study of homeless adults in Los Angeles, California, demonstrated the impact of competing subsistence needs on the utilization of self-defined elective health services.⁶ Health insurance and comorbid conditions, along with structural and social factors (e.g., sheltering status and social support systems), have also been linked in several studies with a homeless person's ability to receive services and the sites at which those services will be accessed.^{7–10} As noted by Carrasquillo et al.,¹¹ the structure of Medicaid managed-care programs has led to large fluxes in eligibility and enrollment of program participants that exacerbates one's ability to have continuity of care, particularly for chronic medical problems. Several authors have also described potential and realized effects of welfare reform on homeless persons and other vulnerable groups.^{12–16} However, scarce empirical data exist to support these claims, and issues of health access, utilization, and need have not been contextualized to a specific special-need population during economic prosperity and system reform.

In this article, we report findings from two cross-sectional, community-based surveys of homeless and urban poor adults in Pittsburgh, Pennsylvania. We specifically assessed changes in demographic composition, source for usual care, self-reported comorbidities, and issues of subsistence between samples of homeless adults interviewed in 1995 and 1997. The changes noted are discussed in the context of the relative economic prosperity in the region at the time and its effect on homelessness, as well as the structural supports for health care to urban poor during the shift to Medicaid managed-care coverage and eligibility restrictions.

METHODS

We compared the findings from two community-based, cross-sectional surveys conducted in 1995 and 1997 of homeless and housed poor adults in Pittsburgh. The surveys used similar methodologies for identifying and interviewing the populations. Responses to survey questions on demographics, health insurance, sources for

usual care, clinical characteristics, and economic resources were compared between survey cohorts.

Study Population

The criteria used for selecting persons for both surveys were as follows: (1) Individuals had to be homeless or housed poor and 18 years of age or older at the time of interview; (2) they must have provided informed consent to participate. We based our definition of homelessness on current federal guidelines.¹⁷ Individuals encountered at soup kitchens or drop-in centers who were living in an apartment or house they owned or rented but who were accessing homeless-specific services were considered "housed poor."

Subject Identification and Recruitment

In 1995, there were 24 community sites used throughout the city of Pittsburgh and Allegheny County to capture a representative sample of homeless and housed-poor adults. These sites had been identified by outreach workers and area homeless persons and from lists supplied by Allegheny County and the United Way of locations frequented by homeless persons. In 1997, the number of sites was increased to 39, reflecting more soup kitchen, "open air," and female-specific interview sites. No interviews were conducted at health care facilities or at sites when any health care outreach was being provided concurrently. In both surveys, all sites were grouped into three categories: (1) emergency shelters, (2) transitional and supportive housing units, and (3) soup kitchens/drop-in centers/unsheltered enclave sites. This was done to ensure adequate representation of all homeless persons, with oversampling of sites frequented by unsheltered homeless persons and those doubled-up in their living arrangements.

Sites within each sheltering group were weighted based on estimated populations and were randomly selected as interview locations every 2 weeks using probabilities proportional to site size (pps) sampling. In 1995, interviewers used convenience selection at the selected sites to identify potential respondents by starting at a designated corner of a facility or area and systematically working to the other end until the quota of interviews for that site had been reached. In 1997, a more elaborate sampling scheme was developed using one of four respondent selection plans depending on site characteristics to ensure random selection of respondents. In both surveys, a list of all participants previously interviewed plus social security numbers, aliases, and birth dates was distributed to the interviewers every 2 weeks to help prevent enrolling the same person twice.

Data Collection

Both the 1995 and 1997 survey were conducted in the spring and summer months. Two trained interviewers conducted the interviews after being directly observed and critiqued prior to the start of the project; one of the interviewers (R.D.) participated in both surveys. Surveys were reviewed each week for completeness and accuracy throughout the data collection phase of both studies. In both 1995 and 1997, respondents were paid \$5 for completion of the survey.

Survey Instruments

The 1995 survey was funded by the Allegheny County Health Department as a part of the Homeless Health Services Utilization Study. The survey instrument consisted of five components: (1) demographics, using sections from the Basic Shelter Inven-

tory^{18,19}; (2) comorbid illness; (3) health care access and services utilization; (4) satisfaction with health care; (5) functional status and social support network. Findings from this study have been reported elsewhere.^{7,9} The 1997 homeless survey was funded by the Center for Substance Abuse Treatment (CSAT) within the Substance Abuse and Mental Health Services Administration. In this study, homeless adults in Pittsburgh were interviewed using a modified version of the National Technical Center (NTC) Telephone Substance Dependence Needs Assessment Questionnaire. It was modified to accommodate face-to-face interviews and to incorporate questions from the 1995 survey. Questions common to both surveys were demographics, health insurance status, personal economics, causes of homelessness, self-reported comorbid illnesses, and sources for usual care.

Methods of Analysis

Responses from the 1995 and 1997 surveys were compared with chi-square tests for categorical variables and independent group *t* tests for continuous variables with a two-sided α coefficient of .05. STATA statistical software (STATA Corp., College Station, TX) was used for all analyses.

RESULTS

Overall, 388 individuals completed the 1995 survey (>90% response rate), and 267 individuals completed the 1997 survey (94% response rate). There were 23 individuals who completed both surveys.

Demographics

As can be seen in Table 1, the mean age of respondents and racial distributions of each sample were not significantly different between 1995 and 1997. However, there were significantly more homeless women surveyed in 1997 (21.7% vs. 14.4%). More 1997 than 1995 respondents reported having at least a high school diploma or equivalent (78.2% vs. 70.6%), and more were employed in a full- or part-time capacity (38.2% vs. 29.6%).

Comparable proportions of respondents in 1995 and 1997 reported living in emergency shelters (29.6% vs. 26.3%), being unsheltered homeless (20.4% vs. 24.1%), and living in transitional or supportive housing units (19.1% vs. 24.8%). Differences were noted in sheltering status among the remaining respondents. Specifically, more respondents in 1995 were housed poor (14.2% vs. 0.4%), while more respondents in 1997 reported staying in a combination of housing arrangements in the months preceding the interview (16.2% vs. 3.9%).

Health Insurance Status and Source for Usual Care

Significantly fewer homeless adults had health insurance in 1997 compared to 1995 (58.6% vs. 70.6%), with most of this difference attributed to less Medicaid coverage in 1997 (70.1% vs. 81.4%) (Table 2). Enrollment in Medicaid managed-care programs was significantly increased during this period (36.4% vs. 24.5%), with comparably less fee-for-service coverage (56.9% vs. 33.8%) in 1997. There was no significant change in the proportion of respondents reporting a source for usual care during this period, but fewer persons reported emergency departments (17.2% vs. 32.0%) and more persons reported shelter-based clinics (16.7% vs. 8.9%) as their source for care in 1997 compared to 1995.

When insurance status was controlled in the analysis, 1997 respondents with

TABLE 1. Demographic characteristics

| Characteristics | 1995 (N = 388) n (%) | 1997 (N = 267) n (%) | P |
|--|-------------------------|-------------------------|-------|
| Age, mean in years | 38.2 | 40.3 | .54 |
| Gender (male) | 332 (85.6) | 209 (78.3) | .02 |
| Race (black) | 303 (78.1) | 202 (75.7) | .47 |
| Marital status (separated, divorced, or widowed) | 131 (33.8) | 104 (39.0) | .17 |
| Education (\geq high school diploma) | 274 (70.6) | 208 (78.2) | .03 |
| US Veteran | 130 (33.5) | 73 (27.3) | .09 |
| Employment (full or part time) | 115 (29.6) | 102 (38.2) | .02 |
| | n = 273 | n = 159 | |
| Reasons for unemployment (disabled) | 136 (49.8) | 94 (59.1) | <.001 |
| | n = 388 | n = 267 | |
| Sheltering status* | | | |
| Emergency shelter | 115 (29.6) | 70 (26.3) | <.001 |
| Transitional housing | 74 (19.1) | 66 (24.8) | |
| Unsheltered | 79 (20.4) | 64 (24.1) | |
| Doubled-up | 50 (12.9) | 22 (8.3) | |
| Housed poor | 55 (14.2) | 1 (0.4) | |
| Combination of above | 15 (3.9) | 43 (16.2) | |

*One missing in 1997.

health insurance were less likely to report being unemployed (40.9% vs. 53.1%, $P = .02$) and more likely to have a self-reported medical comorbidity (38.3% vs. 23.0%, $P < .001$). Those that were unemployed were more likely to report having a disability as a cause of their unemployment (59.1% vs. 49.8%, $P < .001$).

Clinical Characteristics

In 1995, there were 30.2% of Pittsburgh's homeless adults who reported a medical comorbidity, and 36.9% reported a chronic psychiatric condition. In contrast, 56.6% of respondents in 1997 reported a medical comorbidity ($P < .001$), and 44.9% reported a psychiatric comorbidity ($P = .04$) (Table 3). Likewise, the proportion that reported taking a chronically prescribed medication increased from 30.3% in 1995 to 52.1% in 1997 ($P < .001$). The most common self-reported medical and psychiatric conditions in both 1995 and 1997 were hypertension, respiratory illnesses, arthritis/musculoskeletal disease, and depression, with a significantly greater proportion in each of these disease categories reported in 1997. Consistent with 1995 data on self-reported "substance abuse problems," 73.8% of Pittsburgh homeless adults in 1997 either abused or were dependent on drugs and/or alcohol.

When the 1995 and 1997 cohorts were controlled for comorbid medical conditions, two trends emerged. Those persons with at least one self-reported comorbid condition in 1997 were significantly more likely to be taking at least one prescribed medication (19.4% vs. 39.3%, $P < .001$), have a psychiatric comorbidity (16.3% vs. 26.6%, $P = .04$), be unemployed (21.4% vs. 37.5%, $P < .005$), and be unemployed due to a disability (46.5% vs. 12.7%, $P < .001$). In contrast, those persons

TABLE 2. Health insurance status and source for usual care

| | 1995 n (%) | 1997 n (%) | |
|-------------------------|---------------|---------------|-----------------------------|
| Insurance status* | N = 388 | N = 267 | <i>P</i> |
| None | 114 (29.4) | 110 (41.4) | .003 |
| | N = 274 | N = 154 | |
| Medicaid | 223 (81.4) | 108 (70.1) | Overall .01 |
| Fee for service | 156 (56.9) | 52 (33.8) | Within Medicaid <.001 |
| Managed care | 67 (24.5) | 56 (36.4) | |
| Veterans Administration | 21 (7.7) | 20 (13.0) | |
| Commercial | 14 (5.1) | 10 (6.5) | |
| Medicare | 12 (4.4) | 6 (3.9) | |
| Other | 4 (1.5) | 10 (6.5) | |
| Source for usual care | N = 388 | N = 267 | |
| None | 38 (19.8) | 58 (21.7) | .55 |
| | N = 350 | N = 209 | <.001 |
| Ambulatory care clinic | 181 (51.7) | 105 (50.2) | |
| Emergency department | 112 (32.0) | 36 (17.2) | |
| Shelter clinic | 31 (8.9) | 35 (16.7) | |
| Other | 26 (7.4) | 33 (15.8) | |

*One missing in 1997 and 2 uncertain for insurance status.

without a self-reported medical comorbidity in 1997 were much less likely to be unemployed (48.8% vs. 22.8%, $P < .001$) or to have health insurance (47.5% vs. 20.1%, $P < .001$)

Economic Resources

Money from employment (40.9%) followed by general relief/welfare (30.3%) and Social Security (20.6%) were the most commonly reported sources of income among 1997 respondents. Nontraditional and illegal sources for income were also reported by a substantial minority of respondents, with 19.1% receiving money from family or friends, 16.9% selling plasma, 13.9% reporting “hustling” or stealing, and 11.6% begging or panhandling. Data collected in 1995 only queried about primary sources for income, precluding comparisons with 1997 responses.

Self-Reported Causes of Homelessness

When study participants were asked to select items from a list as reasons for their homelessness, economic conditions (no money, no job) were more commonly reported in 1997 than in 1995 (Table 4). Of note, a substantial minority of respondents also reported “no longer receiving general assistance” (28.8%) and “no longer receiving medical assistance” (23.7%) as major causes of their homelessness.

TABLE 3. Clinical characteristics

| Clinical characteristics | 1995 (N = 388) n (%) | 1997 (N = 267) n (%) | P |
|--|-------------------------|-------------------------|-------|
| Medical comorbidity* (≥ 1) | 117 (30.2) | 151 (56.6) | <.001 |
| Hypertension* | 35 (9.0) | 61 (22.8) | <.001 |
| Emphysema* | 3 (0.8) | 35 (31.1) | .05 |
| Arthritis/musculoskeletal condition* | 30 (7.3) | 37 (13.9) | .06 |
| Mental health comorbidity (≥ 1) | 143 (36.9) | 120 (44.9) | .04 |
| Depression* | 55 (14.2) | 100 (37.5) | <.001 |
| Anxiety† | — | 39 (14.6) | |
| Post-traumatic stress disorder† | — | 34 (12.7) | |
| Bipolar disorder† | — | 26 (9.7) | |
| Schizophrenia† | — | 22 (8.2) | |
| Regular medication* (≥ 1) | 116 (30.3) | 139 (52.1) | <.001 |
| Drug or alcohol problem‡ | 286 (73.7) | 197 (73.8) | .98 |

*Missing <5 in 1995.

†Not addressed in the 1995 survey.

‡DSM-IV defined abuse or dependence for 1997.

The proportion (50.0%) reporting alcohol and drug use as a major reason for their homelessness in 1997 is similar to the 49.6% who reported this as a major reason in 1995. However, significantly more respondents in 1997 reported psychiatric problems as a major reason compared with 1995 (31.1% vs. 10.8%, $P < .001$).

DISCUSSION

Vulnerable populations are often the least well equipped to take advantage of economic growth and prosperity. However, this awareness is often lost in the context of encouraging and empowering individuals to reenter the workplace and take advantage of tightened labor markets and wage inflation. Public policies reflecting these intentions have the potential to exacerbate the poverty state of those most in

TABLE 4. Reasons for homelessness

| Major reasons | 1995 (N = 388) n (%) | 1997 (N = 267) n (%) | P |
|---|-------------------------|-------------------------|-------|
| No money* | 130 (34.8) | 201 (75.3) | <.001 |
| No job* | 123 (32.8) | 177 (66.3) | <.001 |
| Alcohol/drug problem† | 183 (49.6) | 133 (50.0) | .65 |
| Psychiatric problem | 40 (10.8) | 83 (31.1) | <.001 |
| No longer receiving general assistance‡ | — | 77 (28.8) | |
| No longer receiving medical assistance‡ | — | 63 (23.7) | |
| Family crisis/domestic dispute | 25 (6.7) | 55 (20.6) | |
| Home condemned/burned‡ | — | 25 (9.4) | |

*Missing <20 in 1995.

†One missing in 1997.

‡Not addressed in 1995 survey.

need at the same time public sentiment assumes a more Darwinian approach to individuals and their social condition. This study sought to look at the demographics, health, and health access issues of urban homeless adults during the mid- and late 1990s both to track the evolving needs of this population and to correlate these features of homelessness with public policy changes during that period.

The data presented suggest that homeless persons in 1997 were significantly more ill with substantially higher rates of self-reported chronic medical and mental health conditions and greater reliance on chronic medication than their counterparts in 1995. Substance abuse as a cause for homelessness and as a self-reported condition was consistent between study years, although mental illness as a cause was significantly higher in 1997. At the same time, significantly fewer homeless persons had health insurance, and care patterns appeared to shift away from emergency departments and toward shelter-based clinics in 1997 compared with 1995. From the data presented, it appears that two factors influenced this trend toward more need and less access.

Greater medical and mental health needs among homeless persons along with less unemployment among those “able-bodied” homeless suggests that a negative selection process was occurring during this period of economic prosperity. When entry-level jobs are plentiful and those “more capable/less-disabled” homeless persons are able to secure employment and economically advance, those that remain homeless will have a higher concentration of need than was previously encountered. This is also consistent with our finding that duration of homelessness was longer for more persons encountered in 1997 (71.9% < 36 months) than in 1995 (81% < 24 months). However, more individuals surveyed in 1997 had some form of employment-earned income, which implies that the economic barriers to leaving homelessness may be higher in a more robust economy. It is also consistent with our findings that economic-based reasons for homelessness (e.g., no job, no money) were more commonly cited by the 1997 sample than the 1995 sample.

These findings are consistent with macroeconomic and population-based studies tracking the effects of per capita income and unemployment on health and social status. Work by Brenner et al.^{20,21} noted an increase in suicides, mental hospital admissions, disease-specific mortality, and state prison admissions associated with increases in the national unemployment rate. The stressful effects associated with economic fluctuation were felt to attribute to this phenomenon. That homelessness is stressful is indisputable. However, homelessness in times of economic prosperity and growing wealth disparities, accompanied by a less-sympathetic public consciousness and more punitive public policies, is potentially an even greater personal stress.

The finding that fewer individuals had health insurance along with a greater reliance on shelter-based clinics needs to be placed in the context of events occurring in Pittsburgh during the two intervening years. In 1995, there was one not-for-profit Medicaid MCO operating in southwestern Pennsylvania. With the passage of HealthChoices and the move toward phased-in mandatory MCO enrollment, two additional organizations had entered the Medicaid MCO market in Pittsburgh by 1997 and were engaged in an aggressive marketing campaign to increase enrollment. At the same time, local community efforts, spearheaded by the federally funded Pittsburgh Health Care for the Homeless and others, had increased the availability of homeless-specific health services, expanding the number of shelter-based clinics, adding a mobile van service, and increasing street outreach. There was no change in the number of hospitals or emergency departments that would have been available to homeless persons in the intervening 2 years and no new

federally funded community health centers. The replacement of Aid to Families with Dependent Children with Temporary Aid to Needy Families had not yet been enacted as of 1997, so any change in health services or reported loss of benefits in 1997 would not be due to this legislative action. However, changes in Social Security Insurance (SSI) and Social Security Disability Insurance (SSDI) eligibility and state criteria for defining "medically needy" adult coverage had been enacted by 1997. The most notable impact was expected to be seen among substance-abusing adults, who now have time-limited eligibility that is treatment linked. This narrower interpretation of being medically needy for Medicaid eligibility is the most likely explanation for the reduced level in 1997 of health insurance, particularly among those persons reporting no medical comorbidities. The full effect of losing general assistance payments (\$205 per month) or Medicaid on homelessness is difficult to ascertain and is most likely an additive factor in defining the homeless condition. This is consistent with an earlier study of homeless persons in Detroit after termination of general assistance.¹⁶

It is interesting to note that, given these structural changes, the overall proportion reporting a source for usual care and those reporting an ambulatory care site as their source for usual care did not change. It can be inferred that the decrease in persons reporting the emergency department as a source for usual care could be related to increased MCO enrollment, with these plans placing greater restrictions on access at this level of care. Similarly, the increase in self-reported sources for usual care at shelter-based clinics reflects on the effectiveness of community-based outreach efforts. Alternatively, these changes may reflect the health care patterns of those homeless persons who only seek care sporadically or due to an acute/episodic process. This would be consistent with earlier research on the 1995 study cohort, which identified factors associated with specific sources for usual care.⁹ What is not clear is whether this shift in utilization was associated with different medical outcomes. While utilizing emergency departments as the source for usual care, particularly for the management of chronic illnesses, is not ideal, whether the care provided in shelter-based facilities is preferable or timelier is also not clear. Additional research that prospectively follows patients and correlates utilization to disease management outcomes is needed.

The heightened concentration and acuity of need among homeless persons comes at a time when homelessness, poverty, and gaps in our system of care have fallen off the public consciousness and appear to assume less societal importance.¹ Those individuals left behind when economic opportunity extends into the ranks of the poor have more physical and mental health needs and disability, yet fewer resources are available to access needed services. In addition to liberalizing and facilitating enrollment in medical assistance programs for this population, street-based outreach, case management, and the provision of wraparound services, all shown to work and to be cost-effective,²²⁻²⁴ need to be implemented aggressively. The data presented suggest that the safety net needs are greater during economic prosperity for those homeless persons left behind.

This study reports data from cross-sectional surveys using consistent, comprehensive, and rigorous sampling methodologies to characterize a traditionally difficult-to-reach population. However, the approach described in this article for longitudinally assessing urban homelessness has obvious limitations. First, the cross-sectional nature of these data does not allow for any causality in our conclusions. Our findings can be consistent with multiple scenarios that would explain differences noted between study years. Possible explanations for the demographic

and comorbidity shifts may be related to underlying health-seeking behaviors, the high prevalence of substance abuse and mental illness, or subtle changes in the economic climate of the region between 1995 and 1997. Differences between the two groups surveyed may also be due to differences in sampling or enrollment differences in 1995 and 1997. Because of different sampling schemes in the two years, it is likely that the 1997 sample is more representative of the Pittsburgh homeless population. The 1997 cohort also more closely resembles findings from a national survey of homeless persons²⁵ and a cohort of homeless adults in Los Angeles, California, sampled using similar techniques.²⁶ However, the fact that there were as many demographic and descriptive variables consistent between samples argues for the reliability of our data, that sampling bias is minimal, and that the differences reported between study years is true. The difference in health insurance rates more likely reflects the difference in eligibility criteria rather than a difference in sampling. The Medicaid eligibility criteria adopted by Pennsylvania in 1996 are also more consistent with the criteria applied by other states, which may explain why the 1997 cohort is more consistent with urban cohorts in other parts of the country. The differences noted in sheltering status between 1995 and 1997 are not explained by the inclusion of more open air and soup kitchen locations in 1997 since one would expect more unsheltered, doubled-up, and housed poor persons to be identified at these sites. It is also important to note that these are self-reported data and as such are subject to recall biases. However, as previously reported, when utilization data from the 1995 sample were compared with actual medical records, there was a greater than 80% concordance.⁷ The use of community health workers for conducting interviews most likely contributed greatly to both the high participation rates and the veracity of the data.

In summary, these data show a significant increase in the prevalence of comorbid illness among urban poor and homeless adults and support the need for heightened public awareness and enhanced services. The benefits of economic growth and low unemployment have not “trickled down” to those individuals who are most destitute and often least able to adapt and take advantage of emerging opportunities. Furthermore, the advent of Medicaid managed care for homeless persons may not be the most appropriate choice, particularly without a vigorous community-based outreach and care effort.

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