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“Housing is Healthcare”: Better Health Through Housing First

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Introduction

Homelessness is one of the great humanitarian crises of modern times. In New York City, one can walk by an apartment building filled with luxury units worth many millions of dollars each, then walk one block over to find a person with nothing to their name but a cup filled with change and whatever meager possessions they carry. The same is true in Paris, London, Berlin, Tokyo, and every other major city in the world: tens of thousands of human beings living in poor health with limited or no access to basic necessities.

When extrapolated to account for the entire international homeless population, the numbers are staggering: an estimated 150 million people worldwide are homeless. [1] Somehow, this is considered an unpleasant but unavoidable part of society—that certain people lack the fundamental necessity of a bed to call their own.

A solution to homelessness itself is enormously complex—implicating issues of infrastructure, funding, and many other considerations—but homelessness is increasingly being viewed as fundamentally a healthcare issue. In the United States, for instance, the Centers for Disease Control and Prevention (CDC) has recognized homelessness as a public health concern, since homeless individuals are at heightened risk for a variety of negative health outcomes. [2]

Secondary to the humanitarian concern of human beings living without the necessities of shelter and adequate nutrition, the cost of providing healthcare for the homeless is significant and disproportionate to the rest of the population. A recent study based on a survey of homeless and

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[1] Heebat Onapa, Christopher F. Sharpley, et al., *The Physical and Mental Health Effects of Housing Homeless People: A Systematic Review*, Health Soc. Care Community (Aug. 21, 2021), https://pubmed.ncbi.nlm.nih.gov/34423491/.
[2] Id.

mentally ill adults in Canada, for instance, found that "[s]ixteen percent of the general homeless cohort and 30% of the cohort with a mental illness were in the top 5% of healthcare users in Ontario." [3] Healthcare spending on the homeless is similarly disproportionate in the United States, [4] England, [5] and around the globe. In Western Australia, for instance, recent data shows that taxpayers incur costs of more than $18 million per year just for mental health treatment for their "rough sleepers," who spend a combined 11,500 days in the hospital annually. [6]

Undeveloped countries with high rates of poverty and homelessness are faced with a distinct set of issues in providing a large percentage of their citizens with adequate resources and shelter. The unfortunate plight of these nations and their citizens presents a different set of issues than those faced by high-income countries like the United States, the United Kingdom, Germany, Australia, Japan, and others. But high-income nations must also address the challenge of providing adequate, cost-effective healthcare for their neediest citizens so that their healthcare spending can be reduced. More importantly, these nations must devise ways to get their homeless population into long-term supportive housing, since homelessness itself causes health issues and leads to negative health outcomes.

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[3] Kathryn Wiens, Laura C. Rosella, et al., *Factors Associated With Higher Healthcare Costs in a Cohort of Homeless Adults With a Mental Illness and a General Cohort of Adults With a History of Homelessness*, BMC Health Serv. Res. (June 6, 2010), https://bmchealthservres.biomedcentral.com/articles/10.1186/s12913-021-06562-6.

[4] Anirban Basu, Romina Kee, et al., *Comparative Cost Analysis of Housing and Case Management Program for Chronically Ill Homeless Adults Compared to Usual Care*, Health Serv. Res. (Feb. 2012), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3393008/.

[5] Nigel Hewett, Aidan Halligan, *Homelessness is a Healthcare Issue*, J. R. Soc. Med. (Aug. 1, 2010), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2913065/.

[6] Marta Pascual Juanola, *The Cost of Homelessness in WA's Public Hospitals and How the State Could Save Millions*, WA Today (July 8, 2021), https://www.watoday.com.au/national/western-australia/the-cost-of-homelessness-in-wa-s-public-hospitals-and-how-the-state-could-save-millions-20210703-p586k7.html.

Evidence suggests that income inequity in high-income countries is growing. [7] This disparity naturally extends to healthcare, with the wealthy enjoying access to the best providers and facilities, while the poor struggle to access healthcare system and often receive inadequate care when they do gain access.

The lower percentage of homeless individuals in high-income countries allows for comprehensive policy decisions and programs which can greatly reduce the homeless population, reduce healthcare costs, and improve health outcomes for homeless people. A growing body of evidence suggests that high-income countries around the world can achieve these goals with widespread adoption of an initiative called "Housing First."

Background

A. Defining Homelessness

While little consensus exists on a universal and comprehensive definition of what it means to be "homeless," [8] various definitions have been posited. In the United States, for instance, the Homeless Emergency Assistance and Rapid Transition to Housing Act of 2009 generally defines individuals and families without fixed, regular, and adequate night-time residence as being "homeless," [9] while "[i]n Europe, people who are living rough (street homeless), in encampments or in emergency accommodation or other designated homelessness

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[7] Deborah K. Padgett, *Homelessness, Housing Instability and Mental Health: Making the Connections*, BJPsych Bulletin (June 15, 2020), https://www.cambridge.org/core/journals/bjpsych-bulletin/article/homelessness-housing-instability-and-mental-health-making-the-connections/9F3CE592DBF5909AF29330FCCE5BD4C4.

[8] Seena Fazel, John R. Geddes, et al., *The Health of Homeless People in High-Income Countries: Descriptive Epidemiology, Health Consequences, and Clinical and Policy Recommendations*, Lancet (July 30, 2015), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4520328/.

[9] *The Homeless Emergency Assistance and Rapid Transition to Housing Act of 2009*, H.R. 1877, 111th Cong. § 103 (2009).

services that offer temporary accommodation, are usually defined as homeless." [10] Similarly, in Australia "[t]here is no single definition of homelessness," but an individual living with inadequate, transient, or non-existent shelter is considered homeless. [11]

B. Incidence and Causes of Homelessness

By any reasonable definition, homelessness is a pervasive issue across the globe, in high-income nations and impoverished nations alike.

One study within the past decade estimated that more than 600,000 American citizens and 400,000 European citizens experience homeless over the course of a given year. [12] According to another study, on a single night "[i]n January 2020, there were 580,466 people experiencing homelessness in America" spread across every state and territory in the nation. [13] In the recent past, more than 116,000 people in Australia were homeless, a number that has likely increased in recent years. [14] Moreover, recent evidence suggests that the number of homeless individuals in some parts of the world is increasing. According to a 2014 study on homelessness in England, "[o]ver the past 3 years the number of homeless people in the UK has increased by 34%." [15] As noted above, these numbers represent the proverbial "drop in a bucket" when set against the number of homeless individuals across the globe. [16]

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[10] Nicholas Pleace, Koen Hermans, *Counting All Homelessness in Europe: The Case for Ending Separate Enumeration of 'Hidden Homelessness'*, European Journal of Homelessness (2020), https://www.feantsaresearch.org/public/user/Observatory/2020/EJH/EJH_14-3_A2_v02.pdf.
[11] Australian Government, *Homelessness and Homelessness Services*, Australian Institute of Health and Welfare (Dec. 7, 2021), https://www.aihw.gov.au/reports/australias-welfare/homelessness-and-homelessness-services.
[12] Fazel, *supra*.
[13] David A. Sleet, Louis Hugo Francescutti, *Homelessness and Public Health: A Focus on Strategies and Solutions*, Int. J. Environ. Res. Public Health (Nov. 18, 2021), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8583397/.
[14] Australian Government, *supra*.
[15] Pippa Medcalf, Georgina K. Russell, *Homeless Healthcare: Raising the Standards*, Clin. Med. Lond. (Aug. 14, 2014), https://pubmed.ncbi.nlm.nih.gov/25099832/.
[16] Onapa, *supra*.

The causes of homelessness on an individual basis are varied, but several common factors have been identified. Homelessness has been generally attributed to a combination of "individual" factors (like poverty, family issues, mental health disorders, and substance abuse disorders) and "structural factors" like lack of affordable housing. [17] Additionally, poor health itself can be a primary cause of homelessness because a health condition's adverse effects may lead to absence from employment, exhaustion of paid and unpaid sick leave, and inability by the individual to perform their daily work tasks. [18]

C. Negative Health Outcomes Resulting from Homelessness

Once homeless for any reason, an individual's physical and mental health are vulnerable to broad adverse consequences associated with inadequate shelter. While homeless people experience health problems like those of the rest of the population, these problems are often more pronounced in the homeless. [19]

Homeless individuals struggle with acute and chronic health issues at a greater rate than the general population. They "are more susceptible to substance abuse, are more likely to suffer from mental illness, and are at increased risk for conditions like epilepsy, chronic obstructive pulmonary disease, hypertension, diabetes, and musculoskeletal disorders." [20] Additionally, homeless people are at a greater risk of suicide and unintentional injuries than the rest of the population. [21]

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[17] Fazel, *supra*.
[18] National Health Care for the Homeless Council, *Homeless & Health: What's the Connection?*, Fact Sheet (Feb. 2019), https://nhchc.org/wp-content/uploads/2019/08/homelessness-and-health.pdf.
[19] Andrew J. Baxter, Emily J. Tweed, et al., *Effects of Housing First Approaches on Health and Well-being of Adults Who are Homeless or at Risk of Homelessness: Systematic Review and Meta-Analysis of Randomised Controlled Trials*, J Epidemiol. Community Health (May 2019), https://pubmed.ncbi.nlm.nih.gov/30777888/.
[20] Stephen W. Hwang, Joanna J.M. Ueng, et al., *Health Insurance and Health Care Access for Homeless Persons*, Am. J. Public Health (Aug. 2010), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2901287/.
[21] Fazel, *supra*.

These increased health risks often culminate in premature death. One systematic review found that homeless people in high-income countries are at a 3-to-11 times higher risk for all-cause mortality than those who are housed. [22] Similarly, the authors of one of the previously mentioned studies note that "[r]ates of morbidity and mortality in homeless people are high compared with the general population, in both relative and absolute terms." [23]

Similarly, a 2020 study on healthcare for the homeless in four European Union countries (Austria, Greece, Poland, and Romania) noted "[t]here is robust evidence that homelessness and the associated life conditions of a homeless person may cause and exacerbate a wide range of health problems, while healthcare for the homeless is simultaneously limited in accessibility, availability, and appropriateness." [24] As noted above, beyond just physical ailments, homeless people are more likely to suffer from mental health issues and substance abuse disorders. [25]

Furthermore, the relationship between health and homelessness goes both ways: poor health can cause homelessness, while homelessness can cause poor health. Homelessness causes health issues related to exposure to the elements associated with rough sleeping, increased susceptibility to physical and sexual violence, increased susceptibility to other forms of crime, and lack of access to facilities where an individual can address their personal hygiene. [26] Additionally, homelessness is "also strongly associated with other experiences deleterious to health, such as poverty (especially child poverty), adverse childhood experiences and substance misuse." [27]

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[22] Baxter, *supra*.
[23] Fazel, *supra*.
[24] Ursula Trummer, Sonja Novak-Zezula, et al., *How Structural Compensation Facilitates Health Care for the Homeless. A Comparative View on Four European Union Member States*, Int. J. Environ. Res. Public Health (Dec. 6, 2020), https://pubmed.ncbi.nlm.nih.gov/33291291/.
[25] Hwang, *supra*.
[26] Baxter, *supra*.
[27] Id.

Homelessness also causes difficulty obtaining medical treatment, with one study noting that "[f]or even the most routine medical treatment, the state of being homeless makes the provision of care extraordinarily difficult." [28] The authors of this study use the example of a diabetes patient, noting that treatment consisting of daily provision of insulin and a controlled diet is fairly straightforward for a housed person, but is "complicated, if not impossible" for a homeless diabetes patient, who does not have access to refrigeration for their insulin, is not able to consistently obtain the needed syringes for insulin administration, and has no way of eating a specialized therapeutic diet, given the limited options at soup kitchens. [29]

Diabetes, of course, is just one of many conditions which are difficult, if not impossible, to treat in a homeless patient. Therefore, consideration must be given to the notion that an individual must be provided with supportive, long-term housing to meaningfully improve their health outcomes, since the health challenges faced by the homeless will likely persist for as long as they lack adequate shelter. These health issues affect the homeless population in every country on every continent around the globe. Understanding of homeless individuals' unique health-related challenges has led to recognition of homelessness as a healthcare issue. [30]

D. The High Economic Costs of Providing Healthcare for the Homeless

Healthcare spending on the homeless is significant and disproportionate to the rest of the population. For instance, studies conducted in England illustrate the high cost of providing health care for the homeless (approximately £85 million annually as of 2010) as well as the

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[28] Institute of Medicine (US) Committee on Health Care for Homeless People, *Health Problems of Homeless People*, National Academies Press (1988), https://www.ncbi.nlm.nih.gov/books/NBK218236/.
[29] Id.
[30] Howard K. Koh, James J. O'Connell, *Improved Healthcare for Homeless People*, JAMA (Dec. 27, 2016), https://pubmed.ncbi.nlm.nih.gov/28027356/.

disproportionate use of emergency services and other health services by homeless individuals when compared to the rest of the population. [31]

The issue of disproportionate spending on healthcare for the homeless is similar in North America. As noted above, a contemporaneous study on the cost of providing healthcare for homeless individuals in Ontario, Canada, found that homeless adults suffering from mental illness were in the top 5% of healthcare consumers. [32] The United States experiences similarly disproportionate spending on healthcare for the homeless when compared with the rest of its population. A 2012 study acknowledged that the approximately 1% of the US population experiencing homelessness disproportionately consumed a range of health-related public services at significant cost to the government and taxpayers. [33] For instance, according to one source, homeless individuals present to emergency departments an average of five times per year at an approximate cost of $3,700 per visit. [34]

Evidence suggests that a large portion of the overall healthcare spending on the homeless comes from treatment for the most high-need patients in the homeless population. The authors of the previously mentioned study, for instance, noted that the most frequent homeless users of healthcare systems in the United States visit emergency departments weekly. [35] A 2017 study on healthcare costs for the homeless revealed similar findings in Australia: "Examination of health care costs incurred by two separate samples accessing homeless support services in Australia showed that the high average health care costs found for these groups was driven by a

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[31] Hewett, *supra*; Medcalf, *supra*.
[32] Wiens, *supra*.
[33] Basu, *supra*.
[34] Green Doors, *The Cost of Homelessness Facts* (last accessed March 27, 2022), https://greendoors.org/facts/cost.php.
[35] Id.

comparatively small proportion of the group." [36] Individuals with a diagnosed mental health disorder and/or long-term physical health disorders were most likely to be among this high-need, high-cost population. [37] Given this data, solutions for lowering the high cost of providing healthcare for the homeless must take the needs of these disproportionate system users into account.

E. The Need to Identify Best Practices for Providing Cost-effective and Adequate Healthcare for the Homeless

While homeless individuals technically have the same inherent right to healthcare as others, various factors associated with homelessness (like the absence of a fixed address) [38] present challenges in the exercise of that right. When homeless individuals can access healthcare systems, they often are high-need and high-cost patients due to lack of resources and poor health associated with being homeless. The aforementioned source noted that "[s]tudies and data collections of various institutions, associations, and research groups confirm that access to healthcare for this group of people is notably difficult and the health risks therefore higher." [39] As such, countries must employ strategies which will increase access to healthcare, improve health outcomes for homeless individuals, and reduce the costs for taxpayers and governments of providing healthcare to the homeless.

Inherent in the struggle to improve healthcare for the homeless is that these people lack meaningful financial resources to contribute to their own care. But basic human decency and

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[36] Kaylene Zaretzky, Paul Flatau, et al., *What Drives the High Health Care Costs of the Homeless?*, Housing Studies (Jan. 20, 2017), https://housingfirsteurope.eu/assets/files/2017/08/What-drives-the-high-health-care-costs-of-the-homeless.pdf.
[37] Id.
[38] Frank Johannes Hensel, *Towards Better Health: Improving Access to Health Care for Homeless People*, Dtsch Arztebl Int. (Oct. 2017), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5963582/.
[39] Id.

concern for one another dictates that the indigent must nonetheless be provided with access to our healthcare systems, especially given that people often become homeless because of factors beyond their control.

The question, then, is how can governments provide their homeless citizens with quality healthcare that is accessible and cost-effective? How is funding generated? And how can we balance the dual concerns of providing healthcare to our neediest citizens while properly allocating limited financial

The answer is to attack the root cause of homelessness by providing citizens with permanent housing as the initial step toward improving these individuals' health. Provision of healthcare for those who are presently homeless is largely a losing battle. As detailed above, homeless people live in inherently unhealthy environs. They struggle with access to healthcare, and even when they can access care its effects are often short-lived because they go from the doctor's office or the hospital right back to an environment which is deleterious to health. These individuals have great difficulty making any meaningful progress toward a better state of physical and mental well-being until they are housed. In the meantime, governments and taxpayers are left to pay significant costs for treatment that is largely futile. To break this cycle of high costs for ineffective treatment, governments around the world must focus on providing their homeless populations with housing as the initial step toward improving their health and reducing healthcare spending.

Analysis

As noted above, homelessness itself causes negative health outcomes, with resultant increases in financial and human costs. Homeless individuals disproportionately use health services, have greater prevalence of physical conditions requiring treatment, and have greater rates of mental illness and/or substance abuse disorders requiring treatment. Since housing is among the most significant determinants of health, the number of homeless individuals must be reduced through provision of housing to reduce healthcare costs and improve health outcomes. [40] While various other considerations inherently factor into the issue of providing healthcare to the homeless at a reasonable cost, this review will focus on how healthcare costs can be reduced by providing housing to homeless individuals, either with housing provided as the initial step in treatment (the "Housing First" model), or only after the individual has satisfactorily complied with certain conditions pre-requisite to receiving housing, like sobriety or participation in treatment programs (the "Treatment First" model).

A. The "Housing First" Approach to Ending Homelessness

The concept of Housing First (HF) was first developed in the United States. [41] In the early 1990s, a New York City program called Pathways to Housing began renting apartments from community landlords and providing them to chronically homeless individuals with severe mental illnesses and/or substance abuse disorders. [42] In contrast with accepted practices at the

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[40] Onapa, *supra*.
[41] Nicholas Pleace, *Housing First Guide Europe*, Housing First Europe (last accessed May 8, 2022), https://housingfirsteurope.eu/guide/.
[42] Tim Aubrey, Geoffrey Nelson, et al., *Housing First for People with Severe Mental Illness Who Are Homeless: A Review of the Research and Findings from the At Home—Chez soi Demonstration Project*, Can. J. Psychiatry (Nov. 2015), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4679127/.

time, provision of these apartments was made without any pre-conditions on the individual's sobriety or enrollment in treatment programs. [43]

The concept behind Housing First is simple: housing programs provide individuals rapid housing intended to be permanent, without their having to satisfy other conditions like maintaining sobriety for a certain amount of time or undergoing and successfully graduating from behavioral health programs or other programs before they are eligible to be housed. [44] Housing First differs from other models for housing the homeless in that sobriety and/or compliance with treatment or service programs are not required. [45] A homeless individual's receiving or maintaining permanent housing is essentially unconditional under Housing First, based on recognition of the principle that it is difficult to pursue other goals or improve quality of life without stable housing. [46]

B. The "Treatment First" Approach to Ending Homelessness

The Housing First approach is in contrast with the "Treatment First" approach. Treatment First has been described as the "default approach…which has characterized the vast landscape of delivery in the United States over the past three decades." [47]

With a Treatment First approach, homeless individuals may receive temporary housing contingent on detoxification, sobriety maintenance, and fulfillment of certain other conditions which qualify a homeless individual as being "housing ready." [48] A recent study notes that

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[43] Id.
[44] National Alliance to End Homelessness, *Housing First* (April 20, 2016), https://endhomelessness.org/resource/housing-first/.
[45] Dennis P. Watson, Valery Shuman, et al., *Housing First and Harm Reduction: a Rapid Review and Document Analysis of the US and Canadian Open Access Literature*, Harm Reduction Journal (May 23, 2017), https://harmreductionjournal.biomedcentral.com/articles/10.1186/s12954-017-0158-x.
[46] Id.
[47] Padgett, *supra*.
[48] Id.

"[h]ousing readiness in this context refers to subjective evaluations by case managers that their clients are mentally stable, not using substances and have sufficient life skills to live without on-site supervision." [49]

Under the Treatment First model, a homeless individual may progress from temporary housing to transitional housing to permanent housing, but only if he adheres to certain conditions regarding mental health treatment and substance use. [50]

C. The Housing First Approach Has Been Successful in Improving Homeless Individual's Health and Lowering Healthcare Costs

Housing First initiatives have resulted in significant success based on reported data from various countries where these initiatives have been implemented.

Housing First is now being used in countries across Europe, including France, Italy, the Netherlands, Spain, Sweden, and the United Kingdom. [51] Data on Housing First's effectiveness in European countries has been described as "robust". [52] Growing evidence indicates that Housing First leads to improved health outcomes in numerous areas, including decreased hospitalizations, less total time spent hospitalized, and fewer emergency department visits. [53]

Housing First's success is perhaps most evident in Finland, where the homelessness rate has dropped to aspirational levels because of strong Housing First initiatives. A 2019 article noted that Housing First has been used in Helsinski, Finland, since 2008. [54] Since then, "[r]ough

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[49] Id.
[50] Baxter, *supra*.
[51] Pleace, *supra*.
[52] Ronnie Michelle Greenwood, Rachel M. Manning, et al., *Comparison of Housing First and Traditional Homeless Service Users in Eight European Countries: Protocol for a Mixed Methods, Multi-Site Study*, JMIR Res. Protoc.. (Feb. 5, 2020), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7055843/.
[53] Baxter, *supra*.
[54] Jon Henley, *'It's a miracle': Helsinski's radical solution to homelessness*, The Guardian (June 3, 2019), https://www.theguardian.com/cities/2019/jun/03/its-a-miracle-helsinkis-radical-solution-to-homelessness.

sleeping has been all but eradicated in Helsinski", and the long-term homeless population in all of Finland has decreased by 35%. [55] Another source illustrates Housing First's success in Finland, noting that its homeless population has steadily declined over the past several decades, and that by 2020, "practically no one was sleeping rough on a given night in Finland." [56]

While Housing First, of course, imposes its own costs (approximately €250m in Finland around the time of the aforementioned article [57]), there were resultant savings in other sectors (including healthcare) totaling approximately €15,000 per housed individual. [58] These savings, coupled with the superior health and social benefits homeless people experience with Housing First, sufficiently offset Housing First's costs.

In Germany, the author of a recent study agrees that "[t]he pivotal point for moving towards a healthier life is the provision of appropriate accommodation/housing for homeless persons," [59] and that federal and state governments should fund Housing First programs. While funding housing for homeless individuals is an issue which requires attention, evidence suggests that the high cost of providing healthcare for the homeless means it costs less to provide permanent housing which will then significantly reduce future healthcare costs. [60]

Housing First's benefits in reducing healthcare costs and providing better health outcomes is also evident in North America. In the United States, data from Texas suggests that "providing permanent supportive housing to the homeless community" reduces taxpayers' spending on healthcare by approximately 60% while also leading to a 77% decrease in inpatient

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[55] Id.
[56] Laurence Boone, Boris Cournede, et al., *Finland's Zero Homeless Strategy: Lessons from a Success Story* (Dec. 13, 2021), https://oecdecoscope.blog/2021/12/13/finlands-zero-homeless-strategy-lessons-from-a-success-story/.
[57] Henley, *supra*.
[58] Id.
[59] Hensel, *supra*.
[60] Angela Ly, Eric Latimer, *Housing First Impact on Costs and Associated Cost Offsets: A Review of the Literature*, Can. J. Psychiatry (Nov. 2015), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4679128/.

hospitalizations of the homeless. [61] Another American study published in late 2020 found that when homeless individuals received housing through a Housing First program, their healthcare costs and need for inpatient and emergency services declined significantly. [62]

Similar benefits are noted in a 2012 journal article detailing the author's experience helping to fight homelessness in Asheville, North Carolina. [63] Between his 2008 move to Asheville and 2012 publication of his findings, the author saw a profound decrease in Asheville's homeless population due to the city's reliance on the seemingly self-evident foundation that "housing ends homelessness" and the extrapolation that "[h]ousing is healthcare." [64]

Once provided with housing, people in Asheville were better positioned to address issues like unemployment, mental illness, and addiction. As in Finland, homeless individuals clearly benefitted once freed from the pressing concern of where to sleep every night. From an economic standpoint, the author noted that "by housing people, we are saving our community hundreds of thousands of dollars each year in unpaid healthcare costs. [65] The author concluded that "[a]s we end homelessness one household at a time, we improve the health of our community members, we improve the fiscal well-being of our healthcare systems, and we improve the quality of life for everyone in our community." [66]

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[61] Green Doors, *supra*.
[62] Kevin Brennan, Kathryn Buggs, et al., *The Preventive Effect of Housing First on Health Care Utilization and Costs Among Chronically Homeless Individuals* (December 2020), https://www.bettercareplaybook.org/resources/preventive-effect-housing-first-health-care-utilization-and-costs-among-chronically.
[63] Daniel G. Garrett, *The Business Case for Ending Homelessness: Having a Home Improves Health, Reduces Healthcare Utilization and Costs*, Am. Health Drug Benefits (Jan.-Feb. 2012), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4046466/.
[64] Id.
[65] Id.
[66] Id.

Housing First initiatives have also been successful in Canada, particularly for high-need homeless individuals. The authors of a recent study based on data collected from homeless people concluded that Housing First "[f]or individuals with high levels of need increased housing stability and selected health and justice outcomes over 2 years in a day with many social and health services." [67] Housing First in Toronto resulted particularly in improved mental health for the study's participants. [68] Another recent comprehensive report on Housing First in Canada puts Housing First's success in profound terms. [69] The authors of this report acknowledge that Housing First was controversial when first introduced, but since its introduction "there have been numerous [randomized control trials] demonstrating its effectiveness and cost effectiveness." [70] Specifically, this review identified Housing First as being "very successful, most especially regarding the primary outcome of enabling people with a mental illness who are homeless to find and maintain stable housing for an extended period of time." [71]

Similarly, recent data from Australia illustrates Housing First's economic benefits. The author of the previously referenced article on HF in Western Australia compares the costs of providing healthcare for homeless individuals in a regular hospital bed (nearly $3,000 per day) and a mental health ward bed ($1,500 per day) versus the cost of "a spot in 24-hour supported accommodation": just $500 per day. [72] The difference in hospitalizations for homeless people in Western Australia versus those provided with stable housing are eye-popping: "…the number of inpatient days for homeless people who had been housed in stable accommodation reduced from

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[67] Patricia O'Campo, Vicky Stergiopoulos, et al., *How did a Housing First Intervention Improve Health and Social Outcomes Among Homeless Adults with Mental Illness in Toronto? Two-year Outcomes from a Randomised Trial*, BMJ Open (Sept. 12, 2016), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5030577/.
[68] Id.
[69] Paula N. Goering, David L. Streiner, *Putting Housing First: The Evidence and Impact*, Can. J. Psychiatry (Nov. 2015), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4679126/.
[70] Id.
[71] Id.
[72] Juanola, *supra*.

a total of 3167 days a year down to just under 70 days, saving the public health system more than $4 million in costs." [73]

In sum, Housing First's success in improving health outcomes, reducing healthcare costs, and improving the lives of indigent citizens is supported by evidence-based articles and studies from around the world.

D. The Housing First Approach is Superior to the Treatment First Approach in Improving Health Outcomes for Homeless People While Reducing the Costs of Providing Care

A growing body of evidence suggests that Housing First is a superior strategy to Treatment First in reducing costs and improving homeless individuals' health outcomes. As noted above, homeless individuals' lack of housing causes a myriad of health issues, including increased incidences of substance abuse disorders. Expecting individuals to address substance abuse disorders and/or mental health disorders while still in the crucible of homelessness is an unreasonable expectation. Conversely, provision of supportive, long-term housing creates a stable foundation from which those struggling with substance abuse disorders and/or mental health disorders can obtain treatment after having escaped the harsh challenges posed by lack of adequate, permanent shelter. Therefore, to lower the human and financial costs surrounding healthcare for homeless individuals, countries should adopt the "Housing First" approach instead of the "Treatment First" approach.

A 2019 study based on data from several European counties considered the impact of Housing First initiatives on homeless adults' recovery experiences versus Treatment First

[73] Id.

initiatives. [74] The conclusion of this study was that, while Treatment First approaches remain more common, "[f]indings indicate [Housing First] consistently predicts greater recovery than [Treatment First] across diverse sociopolitical and economic contexts." [75] Analysis of data from the United States and Canada yields similar results: Housing First was found specifically to increase health benefits while reducing homeless individual's use of health services. [76] Specifically, this study found that individuals given stable housing experienced numerous benefits in a variety of key areas, including improved quality of life, reduced hospitalizations, reduced use of emergency services, and improvements in mental health and substance use disorders. [77] Similarly, the previously mentioned study based on data collected from homeless people in Toronto notes that there has been a shift away from Treatment First models and toward Housing First models. [78]

The widespread success reported with Housing First initiatives indicates that it is prominent among strategies countries should seek to adopt in their efforts to decrease the human and financial costs of providing healthcare for the homeless. The cost of providing and maintaining housing for presently homeless individuals is less than the cost of providing healthcare for homeless individuals once they are exposed to the negative health outcomes associated with being homeless.

Housing First does, of course, have its critics, including those who argue Housing First may lead to negative health outcomes. Proponents of such arguments reason that now-housed

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[74] Ronnie Michelle Greenwood, Rachel M. Manning, et al., *Homeless Adults' Recovery Experiences in Housing First and Traditional Services Programs in Seven European Countries*, Am. J. Community Psychol. (Dec. 2, 2019), https://pubmed.ncbi.nlm.nih.gov/31793001/.
[75] Id.
[76] Yinan Peng, Robert A. Hahn, et al., *Permanent Supportive Housing With Housing First to Reduce Homelessness and Promote Health Among Homeless Populations With Disability: A Community Guide Systematic Review*, J Public Health Manag. Pract., https://pubmed.ncbi.nlm.nih.gov/32732712/.
[77] Id.
[78] O'Campo, *supra*.

people may not use health services and programs, leading to "a lack of incentive to adhere to treatment or abstain from problematic substance use." [79] But there is no evidence offered that a certain amount of such negative outcomes would outweigh those associated with requiring people to achieve and maintain sobriety while still living on the street. The reviewed study which cites this argument notes that, while "[i]mpacts on long-term health outcomes require further investigation", Housing First "would likely reduce homelessness and non-routine health service use without an increase in problematic substance use." [80]

Housing First models are not without their drawbacks. In terms of homeless people with substance abuse disorders, for instance, while "[l]ow-demand supportive housing with no prerequisites for treatment or sobriety has been shown to improve housing stability and decrease public service use for chronically homeless persons with serious mental illness (SMI) and chronic medical conditions" and "[p]ersons [not treated for substance disorder use before receiving housing] had a significantly longer tenure in supportive housing than treated participants", it was also noted that tenants who received housing before substance abuse treatment were more likely to become incarcerated. [81]

One of the most biting critiques of the Housing First model comes from an April 2020 report which argues strongly against Housing First as the chief model to fight homelessness. [82] The author of this study concludes the following:

> Housing First is the dominant policy framework for homeless services. Yet, after years of implementation, communities are not close to ending homelessness. If homeless services

[79] Baxter, *supra*.
[80] Id.
[81] Gerod Hall, Sarah Walters, et al., *Housing Versus Treatment First for Supportive Housing Participants with Substance Use Disorders: A Comparison of Housing and Public Service Use Outcomes*, Subst. Abuse (2020), https://pubmed.ncbi.nlm.nih.gov/29528786/.
[82] Stephen Eide, *Housing First and Homelessness: The Rhetoric and the Reality*, Manhattan Institute (April 21, 2020), https://media4.manhattan-institute.org/sites/default/files/housing-first-and-homelessness-SE.pdf.

> systems can't focus as much on substance abuse, employment, and other social ills as they do on residential stability, those challenges will simply be left to other social-services systems. In light of these facts, a certain reorientation is justified. [83]

Despite its skeptics and drawbacks, Housing First remains the best option in terms of reducing the rates of homelessness, improving health outcomes of homeless people, and reducing healthcare costs of taxpayers and governments. The author of the aforementioned study argues that "[i]t is crucial to parse claims about what is evidence-based and what is founded on humanitarian concerns, intuition, ideology, or some other factor." [84] This author discounts the vital importance of "humanitarian concerns", as though the plight of the least fortunate among us is trivial, while repeatedly attempting to undermine various modes of evidence which support Housing First as an effective overarching initiative to reduce rates of homelessness and improve health outcomes.

Regarding health outcomes, another report on Housing First approached the issue with initial skepticism, noting that randomized controlled trials were needed to truly determine the effectiveness of Housing First, despite empirical evidence showing decreased rates of homelessness at times of increased housing vouchers, increased housing units, and Housing First implementation in the United States. [85] The authors of this report concluded that Housing First reduced individual reliance on in-patient and emergency services, although the evidence was weaker for improvement of clinical and social outcomes. [86]

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[83] Id.
[84] Id.
[85] Jack Tsai, *Is the Housing First Model Effective? Different Evidence for Different Outcomes*, Am. J. Public Health (September 2020), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7427255/.
[86] Id.

Treatment First programs are burdensome for homeless people, who are faced with daily challenges in obtaining necessities like food, water, and shelter. Homeless people are also more susceptible to mental illness and substance abuse disorders, which make achieving the sobriety necessary for obtaining housing under Treatment First programs still more difficult.

One of the above-referenced studies notes that "[a]ccess to safe, secure, and affordable housing is widely accepted as a key solution to address the problem of homelessness and some of the health disparities that exist in homeless populations." [87] Beyond the immediate concern of providing shelter for those in need, evidence suggests that Housing First allows previously homeless individuals to effectively re-integrate into the community, with one study noting that "[p]eople receiving HF achieved superior housing outcomes and showed more rapid improvements in community functioning and quality of life than those receiving treatment as usual." [88]

Based on the above, provision of housing should rightly be placed at the forefront in the fight to reduce homelessness, improve health outcomes for homeless people, and reduce the overall costs of providing healthcare for the homeless.

E. The Medicaid Program is a Logical Choice to Help Fund Housing First Initiatives in the United States

Although Housing First has been shown to improve homeless individual's health outcomes while reducing healthcare spending, provision of housing for the homeless imposes its own set of costs. Housing First programs' success depends on a reliable source of funding so that healthcare savings and improved individual health outcomes can be realized. The public health

[87] Onapa, *supra*.
[88] Aubrey, *supra*.

program Medicaid should become the primary funding source for Housing First programs because HF programs can result in long-term savings for Medicaid.

Policymakers have shown increased interest in reducing the healthcare spending on homeless individuals through use of housing support programs like Housing First since the number of homeless adults covered by Medicaid increased when the Affordable Care Act (ACA) went into effect in 2010. [89] The authors of this study note that "[i]nterest in developing Medicaid-funded [supportive housing] for homeless populations is growing due [to] the ACA Medicaid expansion and a body of evidence that such services can reduce avoidable health care spending." [90] The authors also note that permanent supportive housing models like Housing First are needed to reduce Medicaid spending for the homeless, with the conclusion that "health care spending reductions could offset the cost of targeted Medicaid-funded tenancy support benefits." [91]

Medicaid is the logical choice to re-direct some of its funds toward Housing First initiatives because Medicaid's overall spending on homeless individuals will be reduced if these individuals receive long-term housing. A large percentage of homeless individuals are either eligible for Medicaid enrollment or are already covered by Medicaid. [92] Thus, given that Medicaid largely bears the burden of covering the disproportionate costs of healthcare for the homeless, it stands to reason that Medicaid can reduce its overall spending by re-directing some of its funds toward providing housing for homeless individuals. These individuals will eventually

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[89] Joel C. Cantor, Sujoy Chakravarty, et al., *Medicaid Utilization and Spending among Houseless Adults in New Jersey: Implications for Medicaid-Funded Tenancy Support Services*, The Milbank Quarterly (Jan. 22, 2020), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7077786/.
[90] Id.
[91] Id.
[92] Julia Paradise and Donna Cohen Ross, *Linking Medicaid and Supportive Housing: Opportunities and On-the-Ground Examples*, Kaiser Family Foundation (Jan. 27, 2017), https://www.kff.org/report-section/linking-medicaid-and-supportive-housing-issue-brief/.

require decreased healthcare services as their health improves once they are removed from the harsh environment of the streets.

Studies support the notion that Medicaid costs are reduced by provision of housing. The authors of the previously mentioned study, for instance, note that "research has shown reduced emergency department (ED) use and inpatient hospital admissions, as well as reduced Medicaid costs, associated with supportive housing." [93] Another source notes that emergency department utilization and inpatient admissions can sometimes be avoided through provision of "healthful living conditions" for homeless individuals. [94] The conclusion is that supportive housing programs like Housing First "may therefore be a cost-effective strategy for improving the health of this vulnerable population while reducing spending on avoidable health care interventions." [95]

Housing First programs in New York City have similarly resulted in reduced Medicaid expenditures on individuals suffering from mental illness and chronic homelessness. A recent study noted that a Housing First program in New York City led to Medicaid savings "particularly for individuals with very low Medicaid coverage, increasing Medicaid expenditures, and high Medicaid expenditures pre-baseline." [96]

Greater integration of Medicaid funding with housing programs may also lead to enhanced outcomes for all programs involved. Currently, Medicaid and supportive housing programs operate almost entirely separate from one another, even while they largely serve the same population. [97] Integration of Medicaid funding and housing funding can help to eliminate this disconnect between programs which serve the same population. Indeed, such integration

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[93] Id.
[94] Cantor, *supra*.
[95] Id.
[96] Sungwoo Lim, Qi Gao, *Impact of a New York City Supportive Housing Program on Medicaid Expenditure Patterns among People with Serious Mental Illness and Chronic Homelessness*, BMC Health Services Research (Jan. 10, 2018), https://bmchealthservres.biomedcentral.com/articles/10.1186/s12913-017-2816-9.
[97] Paradise, *supra*.

may result in benefits for both Medicaid and housing programs. The authors of the previously mentioned study note that "[i]n cross-sector initiatives that integrate Medicaid and housing, the whole that results may be greater than the sum of the parts." [98] Medicaid funding can provide housing programs with greater resources to address housing needs, while increased provision of housing for the homeless results in improved health outcomes, thus lowering Medicaid spending. [99]

Importantly, Medicaid's greater involvement in housing funding would underline the connection between social determinants of health as a key factor in improving health outcomes and reducing healthcare spending: "Integration of Medicaid and housing may also foster the mutually reinforcing positive effects of safe, stable housing and access to health care for the vulnerable populations who need both." [100] Benefits of this integration may include reduction of avoidable emergency department visits, reduced hospital admissions, greater housing retention, and, ultimately, improved household income as the housed individual's health and ability to work improves. [101]

Medicaid should also not be viewed solely in dispassionate terms as a program designed only to provide low-income individuals with basic healthcare; rather, Medicaid should be viewed as a program dedicated to improving the lives and health of these individuals. As detailed above, homeless people face significant health challenges as a direct result of living on the streets. To an extent, Medicaid covers needed treatment arising from these issues, but such treatment is largely futile when the patient is repeatedly returned to the same unhealthy environment. This cycle of

[98] Id.
[99] Id.
[100] Id.
[101] Id.

illness and treatment fails to address the root cause of the individual's ailments, which are unlikely to be eradicated unless the individual is housed.

By re-directing a portion of its funding to Housing First initiatives, Medicaid can reduce its healthcare spending while creating meaningful and lasting change in its enrollees' lives. A recent research brief from the State University of New York at Albany powerfully illustrates this point. [102] On Medicaid savings, the researchers concluded that "[a]fter enrollment in [supportive housing], participants demonstrated significant reductions in Medicaid utilization and spending", especially in hospital inpatient and outpatient services, emergency department services, and nursing home services. [103] Most importantly, however, the researchers also noted that Housing First resulted in increased housing stability and "improved client health and stability and lessened need for *all* medical services, including high-cost, high-demand services." [104] This study also illustrates the ripple effect that characterizes Housing First, with the researchers noting that provision of supportive housing also had the potential to reduce state spending in other areas like psychiatric care facilities, addiction treatment centers, and prisons. [105]

The researchers for this study also note that "New York has recognized housing as a critical health intervention." [106] To take it a step further, the evidence for Housing First's effectiveness indicates that it may be *the* critical health intervention. With Housing First, a program like Medicaid can be proactive rather than reactive by providing its enrollees with a safe and affordable place to live. Housing then serves as a foundation from which they can cultivate health and well-being. Funding of Housing First initiatives by Medicaid would provide the dual

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[102] Center for Human Services Research, *Reductions in Medicaid Spending and Service Utilization After Enrollment in Supportive Housing*, State University of New York at Albany, https://www.health.ny.gov/health_care/medicaid/redesign/supportive_housing/docs/hhshp_providers.pdf.
[103] Id.
[104] Id.
[105] Id.
[106] Id.

benefits of improving Medicaid enrollees' overall health while also resulting in reduced spending and more cost-effective provision of healthcare.

Conclusion

High-income countries must address the negative health outcomes and substantial economic costs associated with homelessness. These countries must consider various factors in deciding how to address these issues, including the unique health challenges homeless people face, the needs of high-risk and high-cost homeless users of healthcare systems, and how to fund healthcare for the homeless.

To achieve their goals, countries should rely on "Housing First" programs, which are proven to offer superior benefits to "Treatment First" programs. Housing First programs immediately end an individual's homelessness by providing permanent housing, while creating long-term benefits including reduced negative health outcomes and a resultant decrease in healthcare costs for governments and taxpayers.

In terms of Housing First funding in the United States, Medicaid should take a leading role in provided the funds needed to support Housing First initiatives. Most homeless individuals in the United States are Medicaid-eligible. Medicaid stands to benefit from Housing First because the cost of providing housing for the homeless will be offset by the reduced healthcare spending associated with improved health outcomes for homeless individuals.

Most importantly, Housing First initiatives satisfy the basic human necessity of permanent shelter for our neediest citizens, thus providing a platform for these individuals to

address their health issues, reintegrate into communities, and become happy and productive members of society.