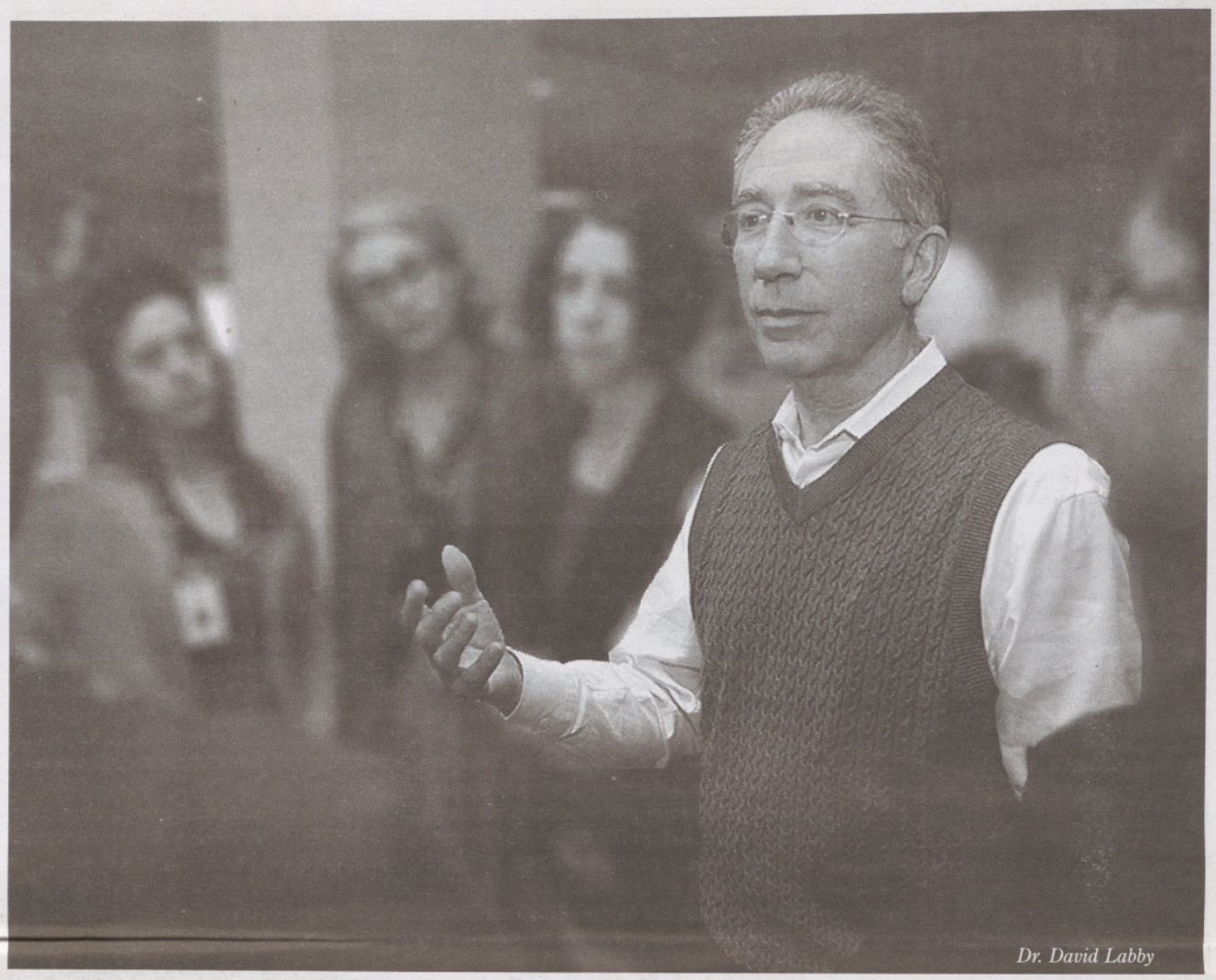
Health care, homelessness, housing and how do we do this?

Dr. David Labby, the chief medical officer with the state's largest health care network, talks about housing as a social determinant of health



Dr. David Labby

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BY CHRISTEN MCCURDY
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Earlier this month, the City Club of Portland released a report – based on a thorough review of academic research, media reports and interviews with stakeholders – concluding what homeless advocates have been saying for more than 20 years: housing is health care. The report recommended doctors receive better training in how to work with homeless individuals, that new Medicaid enrollees receive adequate training in how to access services and that health care funds be reallocated to address one of the root causes of health problems: homelessness.

Dr. David Labby is the chief medical officer of Health Share of Oregon – one of the 16 coordinated care organizations, or CCOs, created as umbrella organizations to oversee physical, mental and dental care in Oregon's Medicaid population. With more than 236,000 members, Health Share of Oregon is the largest CCO in the state, serving the majority of Oregon Health Plan members in Portland's urban core.

In addition to being a medical doctor, Labby holds a Ph.D. in cultural anthropology and has a background in community organizing, calling himself an "unrepentant child of the '60s." He served as a witness for the City Club's health care and homelessness report.

Labby sat down to talk with Street Roots about the study, the connection between health care and homelessness – and how to act on what we know.

Christen McCurdy: *City Club's report on the connection between housing and homelessness argued that housing should be considered a key determinant of health. That expression, "the social determinants of health," is thrown around a lot in policy circles right now. Can you talk a little bit about where that concept comes from and unpack what it means?*

David Labby: We know that if a person had perfect medical care, it would reduce early death by about 10 percent. So the medical system has a role to play. But it's obviously not the majority role.

We know that one of the largest drivers is health behavior – whether you smoke, whether you drink, whether you eat well, if you get enough sleep. That's about 40 percent, so four times as large, in terms of determining your healthy life course, than medical care. Then we know that other things, such as toxins in the environment, play a role. Genetics plays a role. But it's clear that the major factor that determines health is how we are able to live day to day

Obviously a person who has very few resources and is unable to access healthy food, who lives in a neighborhood where there's a lot of community violence and is unable to go outside and exercise and has no resources to go to a gym – those things are going to affect whether or not they will have healthy behaviors. The way we construct society, how we give people access to resources, is a huge part of what determines each part of the population's health.

C.M.: *Where does housing fit into that?*

D.L.: There's been many, many, many studies done that show that a person who is homeless will have worse health outcomes than someone who has housing. When you take the person who is homeless and give them access to housing, their health improves. We've done a study recently here in our own community at the Bud Clark Commons that shows exactly this: People who are part of the Bud Clark Commons, who are able to live there, have better health. They use the health care system more effectively than when they didn't have housing, which totally makes sense.

C.M.: *One of the things that stood out to me about the Bud Clark Commons study is that it seems like we do have a fair amount of information about the connection between housing and health. I mean, there's that study, which is very local and very recent, but Housing Opportunities for Persons with AIDS has been around for more than 20 years now. And it was really created with the idea that if you give people with HIV and AIDS housing, they're more likely to take their medication, they're more able to access nutritious food because they have places to store and cook it, their outcomes are going to be better and they're going to be in hospitals a lot less. So I feel like we've had some information about this for a long time. And yet I also sometimes wonder about these small studies, whether that's really going to translate to a major policy change.*

D.L.: The question is not whether we have evidence. The question is, how do we make the policy change and the economic change and the business model change to be able to provide housing to those who need it? That's the hard issue. In Los Angeles the leaders of the Medicaid program are saying that housing is actually a really important factor in health: Since they are Medicaid and responsible for health, they should be able to pay for housing. But federal law basically says you can't use Medicaid dollars for housing. So the initiative in L.A. is trying to challenge that assumption, but it is not easy to change things that have to happen at the federal level.

CCOs are a major policy change. They are taking the previously separate funding for all medical services, dental services, mental health services, and putting them together in one budget. But this still does not include some of the really important services for the population that is on Medicaid, such as housing. We still have to figure out how we think about a total health organization versus just a coordinated medical care organization. We're trying to go that direction but the the next step is huge, because it will include things like more housing. It's a much larger investment. because we also have the problem in our community that there just isn't enough housing. You have to have a place for people to go. That's mentioned in the report from our community: that the housing stock is not adequate

C.M.: *Part of what's riding on the Medicaid expansion in Oregon is this idea that if we reach out to more people and do a better job of caring for them within the Medicaid population, we can actually save money. And the state's goal is just to slow the growth of Medicaid spending. And it makes sense and*

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