SOUNDING THE ALARM

The Code Red Project and Poverty's Grip on Healthcare

doi: 10.35493/medu.44.08

AUTHORS:
FLORENCE DENG [1], LIZA NOORISTANI [2] & AARANI SELVAGANESH [3]
[1] Bachelor of Health Sciences (Honours), Class of 2026, McMaster University
[2] Bachelor of Science in Nursing, Class of 2025, McMaster University
[3] Bachelor of Arts & Science (Honours), Class of 2027, McMaster University

ARTISTS:
YAHAN LU [4] & CHRISTINA TAM [1]
[4] Bachelor of Health Sciences (Honours), Class of 2027, McMaster University

INTRODUCTION

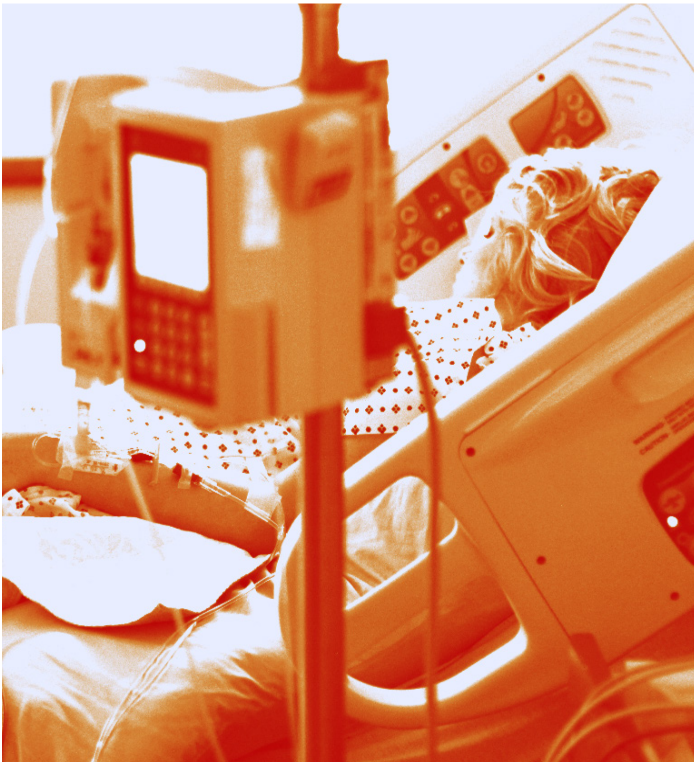
Hamilton is a city of dichotomies. Its dense inner-city and sprawling suburbia constitute a unique microcosm of larger, global wealth inequalities. The entrenchment of poverty has rippling effects on healthcare access and outcomes both within Hamilton and globally, exacerbating discrepancies in the social determinants of health between high-income and low-income populations.[1] Despite having universal healthcare, Canada inadequately addresses healthcare concerns in low-income and homeless populations nationwide and, notably, within Hamilton.

HEALTH IMPLICATIONS IN THE HOMELESS POPULATION

Unfortunately, the effects of homelessness are permeating into the healthcare sector. The relationship between homelessness and health is complex and bi-directional: homelessness can influence health status, and poor health status can result in dispossession.[2] The homeless population in Canada experience a myriad of health inequities and face poor health outcomes in comparison to the housed population.[2] People experiencing homelessness tend to have more emergency department visits and hospitalizations, with higher rates of acute health conditions and mortality.[3] A 2009 study by Hwang et al. found that Canadians experiencing homelessness had a reduced life expectancy compared to the national average of 81 years.[2,4]

The homeless population experiences higher rates of almost all chronic diseases and physical health issues than the general population.[3] These conditions include seizure disorders, diabetes, chronic respiratory tract disease, musculoskeletal illness, dental problems, and tuberculosis.[3] They also experience more general injuries, leading to poor health outcomes. Common injuries tend to relate to the unsafe conditions associated with homelessness, such as using fire to cook food and sleeping on uncomfortable surfaces.[2]

In addition to physical health, mental health issues such as depression, drug addiction, stress, and suicide are prominent among the homeless population.[3] The most common mental illness is alcohol use disorder, with less common conditions being personality disorders, anxiety disorders, affective disorders, drug dependency, and psychotic illness.[2] Unfortunately, many of the basic mental health needs are not addressed, rendering it difficult for those experiencing homelessness to reintegrate back into their respective environments, perpetuating the cyclic nature of poverty.[2] A 2001 study by McCormack et al. found that self-sufficiency and community engagement within homeless populations is contingent on experiencing the feeling of being healthy, underscoring the importance of having equitable access to inclusive physical and mental healthcare.[5]



The homeless population often encounters intersectional barriers, which prevent access to high quality healthcare services. Many people experiencing homelessness report a lack of health insurance or access to healthcare resources, as well as personal barriers such as inadequate social support and feeling isolated from others.[3] The homeless population also experiences difficulty in obtaining consultations with physicians, harm reduction materials, and adequate information regarding available healthcare services.[3] Upon receiving healthcare services, they frequently experience stigmatisation and dehumanisation from healthcare professionals.[6] Inappropriate care and treatment can exacerbate feelings of social isolation and depression, contributing to a vicious cycle of poverty.[3]

THE CODE RED PROJECT

Published in April 2010 by the Hamilton Spectator, the Code Red Project is a seven-part examination of the glaring disparities in health determinants across Hamilton neighbourhoods, mirroring broader implications of poverty on health. Through maps, stakeholder insights, and statistics, the project spurred industry and public discussion.[7]

"Part one: Worlds Apart" maps Hamilton's health status, referencing chief health outcome indicators including average age at death, emergency room (ER) usage, and pre- and post-natal care. Notably, one West Mountain neighbourhood had an average life expectancy of 86.3 years, however, a North End neighbourhood had an average life expectancy of 65.5 years—a difference of an entire generation.[1]

Part two unveils differences in ER dependence due to lack of primary care access. One inner-city neighbourhood averaged $2,060 per person for hospital bed, ER visit, and ambulance use, a drastic uptick from the $138 per person spent on the same services in a Flamborough neighbourhood.[8] Ironically, areas with the best health outcomes are located farthest away from Hamilton's primary hospitals in the inner-city. It is indicative that ER dependence can be predicated on socio-economic hurdles, such as a lack of transportation or family physicians, as well as language barriers.[8] Parts three to five encapsulate the intense struggle within the cycle of poverty, beginning from low birth weights to incongruent high school dropout rates (41.9% to 2.4%).[7] The educational discrepancy later leads to differences in property values ($87,000 in inner-city areas compared to $500,000 in affluent suburbia) and higher rates of low-income seniors stuck in costly acute care limbo.[9,10] The historical and current decline of manufacturing jobs in lieu of high technology positions is a notable exacerbating factor.[7]

Part six hones in on the mental illness implications of poverty, where 25 out of 27 neighbourhoods with the highest rates of psychiatric-related ER visits are in areas with the highest poverty rates.[7]

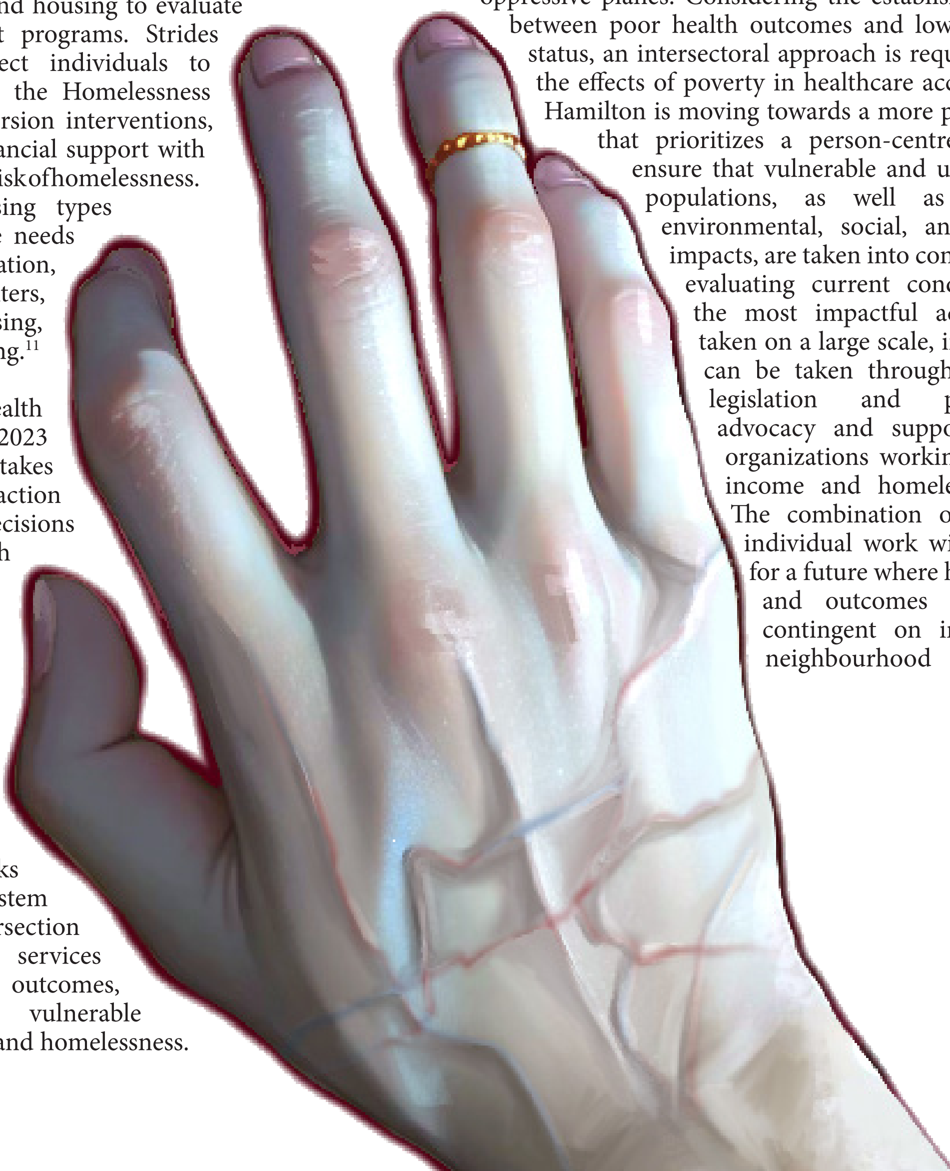
and Ontario Provincial Legislature since its publication.[7] As a result, the City of Hamilton upstarted neighbourhood development strategies. At McMaster University, the Dean of the Faculty of Health Sciences attributed this series as the primary reason for the relocation of McMaster's health campus and medical centre from the west end of the city to downtown Hamilton.[7] Conjunctly, the McMaster Children's Hospital relocated a Children's Treatment Centre from the North End to a site surrounded by prominent, high-poverty Code Red neighbourhoods.[7]

The Code Red project uncovered the degree of Hamilton's income and health disparities, disseminating health information to urge systematic and legislative change.

HOMELESSNESS

The City of Hamilton is working towards a plan to end chronic homelessness by 2025 through rights-based, intersectional approaches that value person-centred and sustainable models that provide long-term solutions.[11] Homelessness and poverty require intersectoral approaches that fuse health and social services. Collaboration between the healthcare sector, governments, and housing services allows for better identification of issues related to poverty and homelessness and the implementation of appropriate solutions as coordinated action leads to policies that create health equity.[12] A greater emphasis has been placed on analyzing outcomes beyond housing to evaluate the effectiveness of current programs. Strides are being taken to connect individuals to financial assistance through the Homelessness Prevention and Shelter Diversion interventions, which focus on coupling financial support with case management for those at risk of homelessness. Furthermore, various housing types are provided for the diverse needs of the homeless population, such as emergency shelters, permanent supportive housing, and transitional housing.[11]

The Greater Hamilton Health Network's (GHHN) 2022-2023 Integrated Strategic Plan takes an intersectoral course of action to improve the quality of decisions made by the Ontario Health Team.[13] One of their main objectives is to implement socio-demographic data to improve health outcomes for equity-seeking priority groups, like the low-income and homeless populations.[14] By taking a multifaceted approach as a part of their Strategic Plan, the GHHN works to create a stronger system that supports the intersection between health and social services to improve overall health outcomes, especially for those in vulnerable communities facing poverty and homelessness.



CONCLUSION

Homelessness and poverty are not independent issues but rather a result of unique intersections between various systemic factors and oppressive planes. Considering the established relationship between poor health outcomes and low socioeconomic status, an intersectoral approach is required to mitigate the effects of poverty in healthcare access. The City of Hamilton is moving towards a more promising model that prioritizes a person-centred approach to ensure that vulnerable and underrepresented populations, as well as the political, environmental, social, and technological impacts, are taken into consideration when evaluating current conditions. Though the most impactful actions must be taken on a large scale, individual efforts can be taken through self-education, legislation and policy related advocacy and supporting grassroot organizations working to assist low-income and homeless populations. The combination of systemic and individual work will pave the way for a future where healthcare access and outcomes are no longer contingent on income level or neighbourhood of residence.

REVIEWED BY: DR. JENNIFER MITTON (PhD)

Dr. Jennifer Mitton is an Assistant Clinical Professor within the Faculty of Nursing at McMaster University. She is currently the Nursing Practice Advisor for the City of Hamilton Public Health Services and has over 20 years of experience in public health nursing.

EDITED BY: PARTH ARORA & ZAHRA TAUSEEF

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