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EDITORIAL

Homelessness: cause and effects

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Abstract

In today's world, wealth accumulates in ever fewer hands. People who live at the margin of the socioeconomic system and are infirm are most prone to become homeless. Many medical and psychiatric problems beset this population. Among them, rheumatic and musculoskeletal diseases are, at the same time, illnesses and barriers to care. Healthcare innovations may decrease the lot of these unfortunate. To correct the root of the problem, we should also set our moral compass to a more egalitarian society.

Keywords Diseases of poverty · Homelessness · Inequalities

Editorial.

We are living sad times. The COVID-19 slow-brewing, lethal pandemics, has no end in sight. Simultaneously, solidarity, which is inherent to most living species, seems to be on the way out from *Homo sapiens*. Values, understanding, and tolerance are being replaced by an insatiable need for material success, covering up remorse with the idea that, by overflow, some spare change will filter down into the rest of society. However, material success does not trickle down. On the contrary, it works as a suction pump.

In today's world, wealth tends to accumulate in ever fewer, ever more predatory, and ever more resourceful hands, both at the global and individual levels [1, 2]. The blanket is continuously being pulled away from those at the margins. Therefore, it is not surprising that despair, anxiety, depression, layoffs, and evictions have escalated over the past two decades, irrespective of medical and psychiatric ailments, in the dispossessed. Of course, malnutrition, mental disability, alcoholism, drug addiction, tuberculosis, HIV, and now COVID-19 are most prevalent among the homeless, who are the weakest of our brethren. Some degree of anesthesia may make their jump to the open space less painful. Street, crevices, parks, and enclosed public areas in cold weather are the only welcoming place for those expelled. There are also shelters that often homeless avoid for fear of violence and acquiring a disease.

There is a difference between the cause and the symptoms of homelessness. In 1993 [3], Mathieu commented that changes in the global economy, namely, deindustrialization in the 1980s, led to discontinuing federal programs, which resulted in the increment of homeless of which only a minority were mentally disabled. To reiterate, mental disease, etc. are not the etiology of homelessness. They are symptoms of the shameful social system we live in today. These conditions have been named diseases of poverty, in which "the most elementary requirements for health are that people must have enough to eat and they must not be poisoned"; "poverty is not a direct cause of disease, but it is the main determinant of influences that lead to disease" [4]. We are at the crest of an oscillation of history that could indistinctly be called: greed crest, poverty crest, or homelessness crest.

Dr. Richard Panush and his team [5], as expected from their profound humanity, social concern, and enlightenment, once again touched my heart and made me think with an essay on rheumatic and musculoskeletal disease care for the homeless. The clinical vignette that opens the discussion describes Mr. C, a homeless man with severe, active rheumatoid arthritis who uses a wheelchair and is out of medications. He was admitted to the hospital for parenteral corticosteroids and methotrexate, physical therapy, and occupational therapy. He improved remarkably to the point of discharge, leaving everyone wonder about his fate. Almost 2 years later, Mr. C returned to the clinic. He arrived with his wife and was no longer using a wheelchair. His rheumatoid arthritis was expertly treated in another clinic and lived in subsidized housing. This story has much to teach

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from a medical viewpoint, but it teaches more from a social perspective. Medically, his admission to the hospital was probably life-saving. In the late 1960s and early 1970s, with fewer barriers, with some frequency, we admitted to the hospital rheumatoid arthritis patients for a "tune-up" with the limited available medications and working closely with a dedicated support team. In Mr. C's case, his improvement initiated a virtuous cycle that moved him from the street to public housing, where he found his home. Of course, this happy ending occurs in Los Angeles, California, USA.

Mr. C's clinical vignette leads the authors to review the health issues that beset the homeless. Shockingly, their life expectancy is almost halved. Homeless people are not spared from conditions such as osteoarthritis, rheumatoid arthritis, polymyalgia rheumatica, systemic lupus erythematosus, plus the miscellany of less common ailments that rheumatologists treat. Given the street situation, diagnosis may be late or never done, and treatment may lack supervision, leading to worse outcomes. The small case-controlled study that follows, centered on rheumatoid arthritis, is revealing. As compared with non-homeless patients, fewer homeless patients kept appointments, fewer had controlled disease, fewer took disease-modifying medications, and almost half were on corticosteroids vs. none of the non-homeless. Based on these data and the literature, Dr. Panush and co-workers make a series of innovative recommendations, particularly developing a rheumatology-aware clinical track devoted to homeless patients' care.

Lucky of Mr. C that lives in an affluent society! In 2018, according to the Economic Commission for Latin America and the Caribbean (ECLAC, or CEPAL) in Mexico, 41.5 and 10.6% out of 127.6 million people lived in poverty and extreme poverty, respectively; in Brazil, 19.4%and 5.4% out of 211.0 million people, and in Argentina 24.4 and 3.3% out of 45.0 million people, respectively [6]. Add to this the migrants that flow north from Mexico and Central America. Although not technically homeless, as most of them have their modest home in their countries, perhaps never to see it again, they live homelessly. The crowds at southern Mexico that limit with Guatemala and on the Mexican side of the USA-Mexican border are egregious local versions of migrants' overflow everywhere that extreme poverty causes.

I believe that Dr. Panush and co-workers' thesis of mitigating homelessness, and the thesis that I espouse, that its cause must be defused, are not mutually exclusive. Their view is realistic, and mine is ideal and perhaps unattainable. But we could not cure tuberculosis with pneumothoraxes, Lucite balls, and sun and clean air. Ultimately, we needed streptomycin.

Acknowledgments When Dr. Carlos Pineda invited me to write this Editorial, I felt at a loss because the subject was out of my field. However, having lived for prolonged periods in Argentina, Uruguay, the USA, and Mexico, I hazily perceived that today's socio-economic order was the ultimate cause, or etiology, of homelessness. Thus, I asked Dr. Hernán E. Gómez, Professor of Anthropology, DCAS, ITR at the Universidade Federal Rural do Rio de Janeiro, Brazil, to help me in this task. He felt that his input was not sufficient to share the authorship, and I respected his decision. I much appreciate his generous help.

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