

The Social Determinants Of Health And Their Role In Rising Homelessness

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Introduction

Homelessness is both a housing emergency and a major **social determinant** of health because stable housing shapes exposure, sleep, hygiene, nutrition, medication storage, safety, employment, and access to care. The latest fully published national Point-in-Time estimate currently available from HUD counts 771,480 people experiencing homelessness on a single night in January 2024, an increase of 118,376 people, or about 18%, from 2023 (U.S. Department of Housing and Urban Development [HUD], 2024). That one-night count does not include every person experiencing housing instability, but it demonstrates the scale of the problem. Homelessness should not be explained primarily through mental illness, substance use, or individual choice. Those conditions can increase vulnerability for some people, but housing costs, inadequate income, low vacancy, eviction, discrimination, institutional discharge, domestic violence, disability, and shortages of supportive housing determine whether a personal crisis becomes housing loss. Homelessness then worsens health and makes recovery harder, creating a reciprocal relationship between housing instability and physical, psychological, and social wellbeing.

Housing Affordability as an Upstream Health Condition

The connection between housing and health begins before literal homelessness. Households that spend most of their income on rent may delay food, medication, transportation, childcare, or medical care, while repeated moves and eviction threats create chronic stress. Current affordability data show how narrow the margin has become for many renters. The National Low Income Housing Coalition estimated that in 2026 a full-time worker would need to earn \$34.73 per hour to afford a modest two-bedroom rental at HUD's Fair Market Rent without spending more than 30% of income, while the average renter wage was \$24.84 (National Low Income Housing Coalition [NLIHC], 2026). This gap does not mean that every rent-burdened household becomes homeless, but it increases exposure to job interruption, illness, family separation, or unexpected expenses. Housing vouchers, deeply affordable units, emergency rental assistance, and eviction prevention can therefore function as health interventions by protecting the basic environment in which treatment and daily routines occur.

Services cannot compensate fully when no affordable unit exists for a household to rent.

Health, Disability, Mental Illness, and Substance Use

Health and homelessness influence one another in both directions. Disability or serious illness can reduce income and increase expenses, making rent harder to sustain, while homelessness can worsen illness through exposure, sleep deprivation, violence, interrupted medication, poor nutrition, and inability to recover safely after hospitalization. Some people experiencing homelessness live with serious mental illness or substance-use disorders, but neither condition is a necessary explanation for homelessness. Symptoms may interfere with work or lease stability when care is inaccessible, and homelessness itself can intensify anxiety, depression, trauma, paranoia, and substance use. A person sleeping outside may use substances to cope with cold, pain, fear, or exhaustion, while a person with diabetes may struggle to refrigerate medication or maintain regular meals. Health systems therefore need housing screening, benefits assistance, medical-legal partnerships, street medicine, and discharge planning. Screening alone is insufficient if no practical referral pathway exists. The goal should be to reduce barriers to treatment while avoiding the assumption that people must achieve psychiatric stability or abstinence before they are considered deserving of safe housing.

Violence, Discrimination, and Institutional Pathways

Homelessness is also shaped by social systems that distribute risk unevenly. Domestic violence can force adults and children to choose between unsafe housing and homelessness, particularly when an abusive partner controls income, identification, credit, or transportation. Racial disparities reflect histories of segregation, discriminatory housing markets, unequal wealth, labor-market inequality, and disproportionate criminal-justice exposure rather than inherent group characteristics. People can also become homeless after leaving foster care, jail, prison, hospitals, psychiatric facilities, military service, or residential treatment when discharge planning fails to secure identification, benefits, medication, transportation, and a safe destination. These pathways show why homelessness cannot be addressed solely through emergency shelters. Prevention requires coordination across housing, healthcare, child welfare, justice, domestic-violence services, and income-support systems. Programs should also recognize different needs among families, youth, older adults, and people with disabilities. A shelter designed for one population may be unsafe or inaccessible for another. Social determinants operate through institutions, so institutional exits and exclusions are as important to prevention as individual case management.

Housing First, Supportive Housing, and Service Matching

Housing First approaches offer permanent housing without requiring sobriety, treatment completion, or proof of “housing readiness” before entry, followed by voluntary supportive services. Research has generally found strong housing-retention benefits for people with long histories of homelessness and complex needs, although health and social outcomes vary and program quality matters (Rolfe et al., 2020). Housing First should therefore not be interpreted as “housing only.” Permanent supportive housing requires reliable rent support, tenancy assistance, behavioral-health care, medical coordination, transportation, and meaningful tenant choice when those services are needed. Other households may benefit more from rapid rehousing or short-term financial assistance because their primary problem is a temporary income shock rather than a need for permanent intensive support. Medical respite can provide a safe place to recover after hospitalization, and street-medicine teams can deliver care to people who remain unsheltered, but neither substitute for permanent housing. Effective systems match intervention intensity to household need rather than forcing every person through the same sequence of shelter, treatment, and readiness requirements.

Interpreting National Counts Carefully

HUD’s Point-in-Time count is valuable because it provides a standardized national snapshot, but it is not a complete census of everyone experiencing housing instability. The count can miss people who are doubled up with relatives or friends, staying temporarily in motels, living in hidden rural locations, avoiding enumerators, or entering homelessness at another point in the year. Weather, shelter availability, local outreach capacity, and methodology also affect estimates. For that reason, one year’s change should not be treated as proof that a particular policy caused either improvement or deterioration. The 2024 AHAR shows a sharp increase from 2023, while the current HUD data page still lists 2024 as the latest fully published national Part 1 report (HUD, 2024). At the same time, 2026 rental data continue to show a large gap between renter wages and the income required for modest housing (NLIHC, 2026). The evidence therefore supports a housing-affordability problem without reducing homelessness to a single cause or political explanation.

Conclusion

The social determinants of health help explain homelessness by showing that housing loss emerges from the interaction of affordability, income, discrimination, violence, disability, healthcare access, institutional transitions, and individual circumstances. HUD’s latest fully published national Point-in-Time report counted 771,480 people experiencing homelessness in January 2024, while 2026 rental data show that the average renter wage remains well below the national Housing Wage for a modest two-bedroom home (HUD, 2024; NLIHC, 2026). These conditions make health crises and other shocks

more likely to result in housing instability. Once homelessness occurs, exposure, stress, interrupted treatment, and loss of routine can deepen existing illness and create new health problems. Effective responses therefore operate at several levels: eviction prevention and affordable housing reduce entry into homelessness; Housing First and permanent supportive housing stabilize people with long or complex histories; rapid rehousing addresses shorter-term crises; and medical respite, street medicine, and coordinated discharge reduce harm while housing is secured. Stable housing is not sufficient to solve every social or medical problem, but it is a foundational condition that makes many other interventions more workable.

References

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