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Housing as a Social Determinant of Health

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Overview

This issue brief highlights our current knowledge on the connection between housing and health, describes what health equity looks like in this domain, and identifies both challenges to achieving health equity in housing and the necessary strategies to change the existing narrative as we move toward health equity.

Housing and Health

In this report we conceptualize housing as a social determinant of health with three main but intersecting constructs: adequate housing conditions, affordability, and residential stability. Inadequate housing conditions are associated with both physical and mental illnesses through direct and indirect pathways. Structural features of the home (e.g., mold, pest infestation, peeling paint, drafts and energy inefficiencies, physical crowding) directly impact health, while affordability (e.g., fear of eviction, housing costs, overcrowding) and stability, defined as frequent moves or in its most extreme form, homelessness, may indirectly impact health.

Poor housing quality and instability have been associated with numerous physical health conditions, including respiratory conditions due primarily to poor indoor air quality, cognitive delays in children from exposure to neurotoxins (e.g., lead) and accidents and injuries as a result of structural deficiencies.(Evans, 2006; Leventhal & Newman, 2010) The mental health consequences of poor housing quality and instability have also been noted.(Chambers, Fuster, Suglia, & Rosenbaum, 2015; Suglia, Duarte, & Sandel, 2011) Housing instability disrupts work, school, and day care arrangements, as well as social networks of both parents and children. Worries over the stability of one's housing situation and poor control over the conditions of one's home can result in distress and subsequent

mental disorders. Children and adults experience poor housing quality and instability differently, with further variations among children depending on their developmental stage. As housing conditions are tied to economic factors, vulnerable populations (i.e., racial/ethnic minorities, families with young children, the elderly, and low-income households) are most likely to be housing insecure and suffer health consequences related to poor housing conditions, residential instability and unaffordable housing expenses. (Rauh, Landrigan, & Claudio, 2008)

New Directions

Recent studies have focused on the impact of remediation of housing conditions and within the context of the great recession and the foreclosure crisis of 2008, more research has focused on the impact of residential stability. For example, mortgage delinquency and foreclosure has been associated with depressive symptomatology as well as lack of use of health services.(Alley et al., 2011; Cannuscio et al., 2012) Newer studies have evaluated the impact of interventions and/or remediation moving the discourse beyond the housing and health connection to evaluate the potential benefit of improving housing conditions. A 2013 systematic review of studies focusing on warmth and energy efficiency interventions concluded that investing in improving thermal comfort can improve general health, respiratory health, and mental health.(Thomson, Thomas, Sellstrom, & Petticrew, 2013) Lastly, emerging work has begun to explore the health impact of displacement or the forced movement of people from their homes and neighborhood. As neighborhoods change more vulnerable individuals/populations, who should benefit from positive neighborhood developments, face greater threats of displacement and missed opportunities to benefit from positive neighborhood developments.

Existing housing narrative

From a social determinants of health perspective, housing is often viewed as a dichotomous issue: one is either homeless or housed, a perspective which omits the various precarious housing situations that people, especially vulnerable populations, may experience. These in-between states of housing include residing in homeless shelters, living in doubled- and tripled-up circumstances with multiple families in one unit and moving frequently between places. As “precariously-housed” populations are considerably harder to reach, their experiences are not well documented in the literature thereby leaving the full continuum of housing and its consequences on health underexplored. Further, the interplay between housing affordability and the conditions of housing are often neglected. In the lived experience, families often afford housing at the expense of health whereby they sacrifice conditions for affordability (Hernández 2014). Further dichotomies ensue between new and existing housing stocks as well as luxury versus affordable housing. New and luxury housing offer the best options for health whereas older units and those constructed for lower-income residents often lack healthful conditions and amenities. Also, despite what is known regarding the links between social capital and health, residential instability is often overlooked as a determinant of health even though the disruptions in the formation and continuation of social and institutional ties that occur due to instability are quite evident (Carpiano 2006).

Health Equity and Housing

Health equity in housing would entail opportunities for all individuals, regardless of race/ethnicity, socioeconomic status, household composition or zip code, to benefit from developments in modern building science, fair maintenance practices and creative uses of

space through programming to form a culture of health and social connections. Homes and buildings would be newly built or renovated to reflect standards such as energy efficiency, adequate space, appropriate ventilation and good lighting. Hazards such as lead paint, asbestos, mold and pest infestation would be permanently remediated. Dependable and timely maintenance responses would be afforded to all. Amenities such as green space, community rooms, play areas, quiet zones along with active design elements such as well-lit and easily accessible stairways and walkways would be standard practice rather than luxury items afforded to market-rate and higher income residents. Smoke-free housing policies would be effectively enforced alongside the implementation of designated smoking areas. Health equity in housing would also involve development subsidies to expand affordable housing at a wider range of income levels. Lastly, land use and zoning policies would support health-promoting institutions and recreational opportunities while also retaining stability of local residents and small businesses as new developments are introduced.

Among the challenges in achieving health equity in housing are a lack of imagination and policy deficiencies that limit the reach of housing to better promote health and equity. For example, as a key social institution, residential settings present an opportunity to connect neighbors via health promoting initiatives such as gardening, walking groups, tenant advocacy, resident watch groups, family activities, emergency preparedness drills and intergenerational cooking classes to demonstrate healthy food preparation and life skills. As it were, housing units are constructed without thought to creating and programming space to cultivate social cohesion. This is important since neighbors that know each other are more likely to feel safe, supported and connected—all important concomitants of health. More imaginative approaches are needed to leverage housing as a convening entity with rich programming potential.

Regarding policy, affordable housing development has largely emphasized providing housing to the very poor in historically disadvantaged communities. In order to achieve equity, affordable housing ought to also be more widely available in high resource neighborhoods, so that the poor benefit from enhanced educational, workforce and health opportunities. Meanwhile, providing decent housing opportunities for moderate-income families, who would also benefit from housing subsidies, can interrupt the concentration of poverty in low-resource neighborhoods, albeit careful attention to the displacement risks of gentrification is critical.

Priority Areas for Achieving Health Equity in Housing

Health equity can best be achieved by focusing on three domains of housing: 1) encouraging the physical design and programming of residential space to promote health; 2) preserving, improving and better connecting existing affordable housing; and 3) expanding supportive housing options for special populations.

Designing and programming housing for health. The physical infrastructure of housing should capitalize on modern building practices that emphasize high performance metrics in energy efficiency, ventilation, lighting, thermal comfort and the use of environmentally sound materials. Doing so is increasingly aided by certifications such as LEED, Enterprise Green Communities, Energy Star and Passive House, among others. Nevertheless, these certifications and the corresponding building practices are often cost-prohibitive for affordable housing developers. Therefore, in order to achieve health equity, more incentive programs need to be developed that apply best practices to all sectors of housing, but especially housing that targets low and moderate-income residents. Once built, the physical spaces should be programmed by management staff and engaged residents to

encourage social connections and resident health through education and the enactment of health-based activities. Such shifts in design and programming practices will improve the structure and culture of residential buildings.

Preserving, improving and connecting affordable housing. The preservation of existing affordable housing along with its modernization, adequate maintenance and connectivity to the broader neighborhood landscape are essential to creating health opportunities for populations most impacted by housing-related health disparities. At a time when the affordable housing stock is dwindling in number and in quality, it is imperative to maintain existing public and privately-held housing and enhance its value and functioning by investing in major capital improvements. Ensuring that affordable housing is integrated into the social fabric of communities and available in a wide array of communities is essential for socioeconomic inclusion rooted in housing.

Expanding supportive housing to neglected populations. Supportive housing for special populations including those affected by mental illness and substance abuse have demonstrated positive results in stabilizing these co-morbid conditions (Padgett et al, 2006). Also, women and children are best supported by the shelter and transitional housing systems as well as by housing subsidies that offer opportunities for permanent, affordable housing. However, there are key populations that are left behind—namely, formerly incarcerated men. In light of the disproportionate impacts of incarceration borne by certain communities, formerly incarcerated populations, especially men who are non-custodial fathers, face many challenges reentering communities and establishing a stable home environment. Further, federal guidelines prohibit any householders with a felony record from residing in public housing. These factors need to be reconsidered in pursuit of health equity

for populations most affected by mass incarceration where housing can be used as an important stepping-stone in starting over.

Conclusion

While existing evidence points to a clear relationship between housing and health, as well as the emergence of research noting the impact of improving housing conditions on health, there are challenges in enacting strategies that would achieve health equity in this domain. Strategies to achieve health equity in housing will need to address multiple constructs: adequate housing conditions, affordability, and residential stability. Paramount to achieving health equity in this sector is the fact that as a multi-sectorial field, housing is not always recognized as an important source of health and well being by stakeholders beyond public health. There is a need to shift our understanding from housing luxuries to housing amenities, which are necessary to foster health, well-being and a sense of community. This shift in narrative will require interdisciplinary collaboration of clinicians, public health practitioners, city and regional planners, developers and architects in considering the health impact of housing conditions.

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