Housing distribution and health profiles

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Background and Scope

This essay aims to raise awareness of the importance of housing studies in locality-based health needs assessment. Our experience consists of gathering statistical information for work on health inequalities in Manchester[1] and a national study of medical re-housing systems[2]. We are both currently employed by the NHS and would not claim to be housing experts. Furthermore, our backgrounds and perspectives differ - sociology and medicine - we have found it harder to find a common language than a shared understanding. Given the circumstances, clarity of argument may not be achievable but we hope that our view from outside the field of housing studies may be thought provoking.

Our intention is to focus on inner-city housing estates, their probable effect on the health profiles of cities and the importance of including housing indicators in profiles for determining health needs.

Health - Needs, Inequalities and Profiles

The Department of Health's definition of need as 'the ability to benefit from health care' leaves many questions unspoken...benefit according to whom? How should competing benefits be prioritised? How should non-health care components of need be addressed? But at least it focuses attention on the types and extent of illness in the local population and the evidence for effectiveness of interventions. In short, it is crude but action-oriented.

Health and community profiles are printed documents which generally aim to describe the types and extent of illness in the local population and the social, economic and environmental context. They are often thought of as a 'neutral' information resources, useful to various professional groups and the general public. If they make policy recommendations at all, they are usually restricted to the broadest terms. Many health profiles present their information geographically, making use of decennial census small area statistics and pointing out the extent of geographic inequalities. The implication is that documented inequalities in health represent un-met need.

The term, inequalities, has come to have a particular meaning. The Black Report differentiated between health 'differences' and health inequalities as

follows:

> There may be differences between species, races, the sexes and people of different age, but the focus of interest is not so much natural physiological constitution or processes as *outcomes which have been socially or economically determined*[3].

Health inequalities, then, can be thought of as that component of health differences which is amenable to change in the social and economic structure of society. A causal relationship between socio-economic disadvantage and ill-health was plausibly argued for in the Black Report and in subsequent work, but has been far from universally accepted. An alternative view is that social position is best thought as the result of numerous interacting variables rather than the outcome of material advantage/disadvantage alone. In this view, the social patterning of ill-health is associated with disadvantage through social selective mechanisms.

Whichever position the reader holds in this debate, the selective mechanisms themselves cannot be ignored. From the epidemiological perspective, if one considers material disadvantage as a cause of ill-health, the potential confounding effects of factors such as gender, ethnicity and housing status should be explored. But even if one does not assert any *a priori* causal relationship, the effect of social patterns, especially social divisions, is no less a pressing concern of health needs assessment.

For health profiles to be valuable planning tools, they must begin to develop a broadly accepted understanding of the social and health patterns they describe and the mechanisms which give rise to them. We believe that housing allocation is a fundamental mechanism which cannot be replaced by material advantage/disadvantage alone.

'Health Inequalities and Manchester in the 1990s'

This hundred page book, edited and co-authored by one of us, presents maps and bar charts of census, environmental and health variables. It was written by officers of Manchester City Council and Manchester Health Authorities and published by Health For All in Manchester. It combines the thirty-three electoral wards of the City of Manchester into ten sub-areas, and describes health and socio-economic gradients across them. The central wards of Manchester - Hulme, Mosside and Ardwick (referred to as 'Central A' in the document) - had the highest all-causes mortality, post-neonatal mortality, male lung cancer deaths and female coronary heart disease deaths in the City of Manchester. They also had the most unfavourable social and economic indicators, including: %unemployment; %car ownership; housing benefit

claims; reported assaults and burglary rates. In terms of housing tenure, they had the lowest rates of owner occupation. While figures for the type, date of construction and %unfitness are not available for the central part of Manchester, low proportions of owner occupation generally follow the distribution of undesirable housing.

In summary, the area in Manchester with the worst indicators of employment, disposable income and crime, also had the poorest health and housing status.

Spatial Distribution of Housing Types and Quality

Within living memory, major slum clearance programmes removed a great deal of the worst unfit housing and often replaced it with publicly provided estates of houses of uniform construction, or decanted residents into similar 'overspill' estates on the town's periphery. The Housing Act (1956) stimulated an accelerated phase of inner-urban high-rise development which lasted until 1967. The negative effects of these 'social engineering' developments on individuals' health and wellbeing have been documented. Without entering a discussion of these effects, our point is a simple one: the range of values of geographically defined health indicators across a town depends to a large extent on housing distribution and access to housing. If people were randomly distributed across urban space, there would be no observed geographically defined health inequalities. The greatest segregating influence is the geographic location of housing types.

The location, homogeneity and extent of housing types change slowly with time in planned and unplanned ways - they are relatively fixed - but the social selective mechanisms whereby people move between housing types are more rapidly responsive to policy changes.

Health and Social Selective Mechanisms in the Housing System

Systemic Factors. First, there are factors inherent to all housing systems, whether publicly provided or private. Given a scarcity of good quality housing, and even in the face of a well-operated equal access policy, less desirable dwellings become available more frequently than others - in short, when people get where they want to be, they tend to stay put. Hence people with urgent housing needs, such as homeless people, have a greater chance of finding themselves in unsuitable accommodation. Secondly, there is a tendency for people who have a history of being difficult tenants ('hard to place') gravitating into less desirable accommodation. Thirdly, landlords and providers have a vested interest in not allowing areas to go 'visibly down hill'

by keeping the proportion of boarded-up properties to a minimum. As well as placing the provider or landlord's interests above those of the individual tenant, this factor puts pressure on Local Authority officers to allocate quickly, further weakening the ability to allocate according to need.

Self-Selective Factors. First, as housing in an area deteriorates to the point where repairs and renovations are not contemplated, rents may fall to very low levels, or even no longer be actively collected. This price signal tends to attract those on the lowest incomes, and arguably those who have more urgent priorities than looking after their health. Secondly, such areas may become centres of 'alternative' sub-cultures, which then attract like-minded individuals. Thirdly, another inducement to move to a deprived, inner-city estate may be the presence of established informal economies (more on this below). However, the sense of community and security of those who do not belong to such sub-cultures or informal economies may be undermined. People who have lived in an area since before it 'went downhill' often cite fear and insecurity as prime health risks.

The justification for asserting these self-selective factors comes from personal familiarity with the biographies of a few people living in Hulme Crescents. Published longitudinal health studies have to date signally failed to include detailed housing histories[4].

Ill-Health Factor. Mobile, vulnerable populations who are selected into areas of poor quality housing by the mechanisms described above, may, through the accelerated onset of ill-health, become less mobile, socially and geographically, and hence be 'entrapped' by their built environment.

Policy Factors. Recent national policy has focused on the boundary between the public and private housing sectors. The legal prevention of local authorities from building new public housing and the selective sell-off of more desirable council houses under the Right to Buy Scheme, has residualised public housing stock. And the relative failure of the private rented sector to provide affordable, good quality accommodation, has resulted in the most vulnerable clients having increasingly narrower choice. National policy is tending to concentrate those with greatest needs in inner-city estates. Local policy may also help to form the character of particular estates. For instance, families with young children were not accepted for residence in Hulme Crescents after a small child fell from an access walk-way. Young, single adults therefore form a large proportion of those eligible to live in the Crescents.

Measuring the Effects of Housing on Health

Even if selective mechanisms did not operate, a large body of research suggests directly adverse effects of bad housing on health (for a recent review and discussion, see Byrne and Keithley[5]). Work has tended to concentrate on relationships between dampness and childhood asthma, high-rise dwelling and depression, and coldness and excess mortality from strokes and coronary heart disease. It has fuelled a debate on attribution. Some studies have argued that the observed associations can be explained by intervening factors such as smoking or social class. If these 'causes' were truly amenable to intervention and there was a commitment to act, then precise attribution would be justified. But 'partialling-out' ill-health among a group of putative causal factors may simply lead to problem diffusion and victim blaming. There is also the issue of definition of bad housing. One study found that *good quality* high-rise accommodation was not associated with depression.

A general review of health care and measured quality of life (QoL)[6] discussed the relationship between area of residence and QoL. A positive correlation was described between the undesirability of areas and low average QoL score of residents, even when several other factors were taken into account. This result was much weaker, however, when measured on the same variables, but for individual residents. Measurement artifacts can not be ruled out, even when interpreting well designed surveys, but one explanation of these seemingly incompatible results lies in the large inter-individual variation in QoL. Although the average QoL tends to be lower in poorer areas, the variation between individuals residents' QoL is still large. If it is believed that high scorers living in poor areas genuinely do have good QoL, one is led to think that individuals have differing perceptions of adversity and differing capabilities to adapt to it. This phenomenon of adaption raises a seemingly irreconcilable ideological dilemma. Left wing views tend to define equity in terms of equalising general conditions, whereas right wing views emphasise the value of individual triumph over adversity. Whatever one's view, it is well to remember that geographically defined indicators do not represent the positive experiences of a minority of individuals.

After all, valuable insights into health maintenance may come from the question, posed by Antonovsky[7], 'Why do some people remain well in the face of adversity?'. In the experience of one of the authors, people living in inner-city areas tend regard average measures of poorer QoL and higher premature mortality as a put-down. They are less pessimistic than the author about finding ways to improve their local surroundings and improve their lives generally.

The Influences of Deprived Inner-City Estates on General Urban Living

We have suggested that the spatial location, extent and homogeneity of housing types are a major determinant of observed health inequalities across towns. So far, our critique has rested at the level of the behaviour of individual tenants, landlords, providers, planners and builders. But there are also several important levels of group behaviour. The following factors support the treatment of estates as discrete entities rather than collections of individual households.

Informal Economies. The existence of informal economies in the UK can be inferred from routinely collected data. The sum of income tax payers and unemployed claimants is less than the estimated total population. Moreover, the number of people who are 'invisible' to the formal economy tends to rise during periods of trade recession. The precise operation of local informal economies is clearly difficult to define, but they are worthy of consideration for several reasons. First, it is said that cash economies are an important source of income for many estate residents. Businesses and waged householders in the vicinity benefit from cheap, casual labour but the rewards for residents are short term. They receive no job-security, status or long term financial stability. Secondly, not only do residents sever links with the wider state, but conversely estates may become 'no-go areas', where trades people will not deliver and officers of the statutory services 'turn a blind eye'. Third, non-cash networks of exchange serve to facilitate crime.

Cultural Character. Residents of estates may form an age (and cultural) cohort which moved in when the estate was built, typically as young adults anticipating starting a family. Forty years later, as they die, there may be a sudden change in the character of the estate. The character of an estate interacts with the general cultural and symbolic life of the town. Dereliction, bad reputation and graffiti may serve complex social functions: on the one hand, providing a tangible basis for reports of social disintegration in the media; and on the other hand, exerting a conservative influence on the slightly better-off by presenting a spectre of the consequences of social failure.

An Ecological Perspective on Health and Housing

For us, the word ecological carries the meaning of self-regulating dynamic systems in which the whole is greater than the sum of the parts. This idea suggests a useful framework for thinking about housing and health. If one approaches the problems of urban dwelling with, as it were, a clean sheet of

paper, some ecological pre-requisites for successful functioning come to mind.

Adaptive Dwellings. At the individual level, dwellings should be capable of adapting to a range of climatic conditions. They should provide affordable warmth in winter and be easy to ventilate in summer. Furthermore, the locality should be capable of healthy growth and resistance to the damaging effects of economic recession.

Diverse and Sustainable Localities. The mixture of housing types should be diverse with respect to survival mechanisms. The chief survival mechanism of an urban area is local employment. Where housing is not contiguous with work places, it can only be kept alive by artificial means -costly transport systems or unemployment benefits. Both of these means have a de-stabilising effect on community cohesion. Living close to the work place implies that blue and white-collar workers will share amenities and thus have a stake in the local environment.

Indicators of Urban Health

We believe that the creation of adaptive, diverse and sustainable inner-urban dwelling depends fundamentally upon economic regeneration. The introduction of contracting culture into local government raises the possibility of commissioning agencies forming corporate links with local business. Agencies whose primary responsibility is the wellbeing of local people would then have their fingers on the pulse of the local economy.

Indicators of health and wellbeing could be considered in three levels of importance to local planning and decision making, as set out below. This typology is not meant to reveal any new truths about the nature of society, but to put small area health inequalities into a context, and to stress the importance of multi-sectoral collaboration extending beyond statutory agencies.

Primary. A set of indicators of successful, diverse local business and opportunities for micro-economic development. The grimmer the picture, the more the need for long term, planned health and social services!

Secondary. A set of indicators of the extent and distribution of the social dividend from local industry and from welfare. And a set of indicators of the spatial distribution of residents with respect to their economic position. (Council tax bandings are unfortunately too broad to define the boundaries of homogenous areas of housing - nearly 70% of houses in Manchester are in band A.)

Tertiary. A set of small area indicators morbidity and mortality. Traditional

and innovative health indicators could then be properly interpreted in the light of primary and secondary social indicators.

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