Housing, Health, and the Neighborhood Context

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The work of the Task Force on Community Preventive Services (the Task Force) joins a growing body of literature confirming the critical importance of neighborhood conditions to health in America. Saying simply that the "incidence rates are not spread evenly across a region" understates the reality. The fact is that, in virtually all regions of the country, health problems are *highly* concentrated in a small share of all neighborhoods—typically those that rate highest on a number of indicators of distress.

You can explain this outcome in two ways. The first is to note evidence that the types of people that have much higher probability of poor health—low-income people of color for the most part—are highly concentrated in these distressed neighborhoods. The second is to rely on the growing evidence that other conditions in those neighborhoods (e.g., high levels of crime, deteriorated but still high-priced housing) have an effect in undermining health that may be independent of the race and income of the residents.

The role played by housing is particularly important. Indeed, public policy concerning housing in this country emanated largely from perceptions about the effect of housing on health. Slum housing conditions in our burgeoning industrial cities of a century ago — overcrowding plus the lack of light and air, of decent plumbing and kitchen facilities, of adequate heat and, in some cases, of basic protection from the elements—were seen as major contributors to illness and disease. Programmatic responses ranged from the nation's first building and housing codes to, later on, slum clearance and public housing.

Today, housing quality and overcrowding problems are less severe than in the past, but they have not vanished and they have been joined by another significant housing challenge: affordability. A sizeable share of the households in these troubled neighborhoods have to pay more than half of their incomes for rent. Given restricted incomes and the paucity of housing subsidies, these households are living on the edge. Any illness or family disruption that causes them to lose their income stream even temporarily can lead quickly to eviction. Much higher-than-average rates of moves from apartment to apartment in these neighborhoods attest to the seriousness of the issue. It has been shown that *stress* brought about by living in crime-ridden areas can undermine health and that the impact gets more serious the longer one is exposed. It is not unreasonable to assume that prolonged stress brought about by recurrent fear of homelessness works the same way.

Sorting out exactly which causes which is difficult, but we do not have to do that with precision before we begin action. The conclusion is inescapable that health policy needs to focus more on populations and conditions in these distressed neighborhoods. What can be done? There are many possible themes for response. I note only three:

The first is to endorse the Task Force's recommendations related to the expansion of *Section 8 housing vouchers*. While vouchers no longer work as well as they did in our tightest, highest-priced housing markets, they are still the most effective means of delivering housing assistance in most of the country. They reduce budget pressures for families quite directly, give them a wider array of choices as to where they can live (i.e., so at least some of the current residents of the most distressed neighborhoods can move out to less problematic environments), and deliver housing assistance at much lower cost to the public than project-based housing programs.

So far, public health professionals have generally missed an opportunity in this regard. The time when low-income families move out of a troubled neighborhood is a time of heightened awareness for them; a time when they are looking for ways to better their lives. Accordingly, it should be a time when counseling about health risks and health care should have high payoffs. Public health professionals should be taking the lead to develop *health risk counseling modules* and present them as a part of the broader counseling programs that Public Housing Authorities offer to new Section 8 recipients. These efforts could include help to the uninsured among them to obtain Medicaid or other forms of health insurance, and specific guidance to link recipients to good primary healthcare arrangements in their new neighborhoods.

The voucher approach is not a complete solution, however. I believe that direct action within distressed neighborhoods will continue to be essential as well, and in this regard I would emphasize a *community building* approach, my second theme. Community building entails engaging neighborhood residents in their own improvement initiatives; reducing isolation (many believe isolation is the most severe constraint in these

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communities) and getting them to work together and build mutual trust and social capital in the process.

To be sure, improvements in healthcare delivery by professionals are needed inside these neighborhoods as well. But it seems doubtful that meaningful *prevention* will ever occur if the residents themselves do not come to care more about their own futures, be more aware of opportunities for enhancing them, and then start to build trusting relationships with others who can help them in this regard. Public health professionals ought to be more aggressive in creating opportunities to partner with neighborhood associations, faith-based institutions, and community development corporations that work in these ways.

There are several things they could do. One would be to assure that healthcare and prevention counseling are always built into the neighborhood-based multiservice centers that are sometimes yielded by housing programs. Another would be simply to offer the kind of health risk counseling noted earlier in conjunction with other community-building efforts that bring residents together, whether it be renovating abandoned housing or cleaning vacant lots. In other words, schedule a series of events in conjunction with these programs to raise resident awareness and understanding of health risks, engage them in thinking about ways of addressing them, and better connecting them to the formal healthcare system.

My third theme emphasizes the provision of better data to motivate more forceful improvements to healthcare delivery in these areas. It remains true that we do not know enough about the relationships between neighborhood conditions and health outcomes. Most cities do not have up-to-date information at the neighborhood level and the lack of such information is often a barrier to forging a consensus on action. Local data intermediaries from the 19 cities that belong to the National Neighborhood Indicators Partnership (NNIP, coordinated by the Urban Institute), have built recurrently updated information systems that do respond to this need and give evidence that this accomplishment should be feasible in almost any city. Better information of this kind should not only tell us more about how and why health problems become so pronounced in these neighborhoods, but also provide clues about actions that can be taken to address them. Public health professionals ought to learn more about how neighborhood information systems can help them in their jobs. They should partner with the intermediaries that operate such systems in cities where they exist and promote their development where they do not.

It makes sense, of course, for public health professionals to give first priority to strengthening the healthcare delivery system in distressed communities. But my three themes illustrate that there are other things they can and need to do as well to address the deepening health problems of these areas. The more we learn about troubled neighborhoods, the more we recognize the interconnectedness of the issues they face. Health issues are not going to be fully addressed if housing, public safety, and work force development issues are not addressed as well. Creative partnering by professionals in traditionally separate fields is indeed among the greatest needs at this point.

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