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# Housing as a Socio-Economic Determinant of Health: Assessing Research Needs

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## 1. The relationship between socio-economic status and health

Among the affluent countries of the world, researchers have observed for over a century a strong relationship between an individual's socio-economic status and his or her health status. The relationship appears to be independent of the measure of socio-economic status (income, education, job class) and of the type of disease.

Explanations for the social gradient in health cannot be reduced to behavioural factors (smoking, diet, exercise), genetics, or access to health care. Nor is the relationship confined to the margins of society – studies routinely find evidence that the social gradient in health spans the entire social spectrum.

Efforts to develop policy interventions to redress socio-economics inequalities have been thwarted by the inadequacy of current explanations of the pathways and generating mechanisms of health inequalities. The research base, while compelling and remarkably consistent, uses indicators of social and economic circumstances that are too abstract to offer much policy guidance. Moreover, policy prescriptions that encourage raising incomes, improving social benefits for the poor, and narrowing income distribution go against the now well-entrenched retreat of the welfare state.

Such investments become all the more difficult to justify when the interventions of competing policy sectors, such as the health care sector, appear to have a more direct causal pathway between an intervention and a (potential) health benefit. Health inequalities research needs a much more sophisticated model of the connection between socio-economic circumstances and health.

## 2. Where housing fits in

One way to approach the links between socio-economic status and health has been proposed by Lynch and Kaplan (1997), who call for an "epidemiology of everyday life." Systematic social differences in health may be a response to systematic differences in the quality and stressfulness of daily life. If so, housing is one way to understand socio-economic geographies of everyday life and their influence on health.

However, housing is more than just a research approach, it is also a medium through which socio-economic status is expressed and through which health determinants operate. These forces particularly influence the health of vulnerable and marginalized groups in Canadian society, including seniors, children, people with disabilities and chronic illnesses, and members of First Nations. Yet research on socio-economic dimensions of housing and health is underdeveloped.

## 3. Research approach

In response to the dearth of research, an interdisciplinary team of researchers, in partnership with the National Housing Research Committee and the Canadian Housing Renewal Association, conducted a national stakeholder consultation to identify needs, gaps, and opportunities in the area of housing as a socio-economic determinant of health.

This consultation took the form of an electronic questionnaire and eight one-day regional workshops across Canada. Participants included people and organizations in the housing sector, the health sector and those at the interface. It included academic researchers, gov-

ernment policy and research staff at all levels, and people working in government and non-government organizations involved in the delivery of both housing and health services.

The study also included an environmental scan of completed research, the results of which are available at www.housingandhealth.ca.

## 4. Research framework

The research team used the framework shown in the table below to organize the workshop discussions. This model identifies seven dimensions of housing (left-hand column) that have the potential to generate social inequalities and, either directly or indirectly, health consequences. These dimensions may combine with other types of social disadvantage and vulnerability among several population sub-groups (right-hand column) to undermine health and development. The model implicitly poses the question, "Are some groups in society more vulnerable to health effects of socio-economic dimensions of housing and domestic life?"

| HOUSING DIMENSION | SOCIO-ECONOMIC CATEGORIES |
|---|---|
| Physical hazards | Owners/renters |
| Physical design | Different income levels |
| Psychological benefits | Family/household status |
| Social benefits | (Dis)ability |
| Political dimensions | Mental illness |
| Financial dimensions | Life stage (particularly children & seniors) |
| Location | Gender |
| | Ethnicity/immigration |
| | Aboriginal status |

The seven dimensions of housing are discussed in more detail below.

### Physical hazards

There are well-founded concerns about housing disrepair and exposure to toxins and hazards (such as moulds or dust mites) that sub-standard housing may entail. There is already a rich body of research on the health effects of physical hazards in the home, but a dearth of research on the intersection between physical hazards and socio-economic factors. Addressing this intersection would raise the following questions: Do people of lower socio-economic status experience a systematically greater exposure to biological, chemical, and physical hazards in the home? Is there a systematic socio-economic bias in the capacity for households to redress such hazards, for example, through the uptake of housing improvement programs?

### Physical design

Physical design can contribute to health status in a variety of ways. For example, stairs or floors in disrepair pose the risk of falls and accidents, particularly for people with mobility and balance problems. The absence of adaptive equipment such as handrails or inadequate fire escape routes may also be health risks.

Design factors may be influential in creating living spaces that allow for rest, privacy, refuge, and surveillance zones, while in multi-unit dwellings, design features may facilitate safe and appropriate social interaction. Architects, landscape architects, and environmental psychologists conduct research on these topics, but it is not well-recognized in the housing and health literature.

### Psychological dimensions

The home is an important expression of identity and social status, as analyses of real estate advertising clearly show. Home ownership may also provide an added sense of security that has long-term health benefits.

Some researchers have argued that the relationship between socio-economic status and health is not just a matter of people's material circumstances, but also the meanings people attach to their material circumstances. This proposition is largely untested, but the importance of the home as a site for the investment of meaning would be a logical avenue for research.

A second psychological dimension of housing concerns the notion of control. Of all the spaces we occupy in our daily life, home is the only space where we are socially (and legally) sanctioned to have complete control. There is already a large literature on job stress and health which relates a lack of control to the development of heart disease risk factors and mental health issues. If control is important in the workplace, it follows that it should be important in the domestic sphere.

### Social dimensions

The home is an important site for the development and maintenance of social relationships. The importance of social support is already well established in the health literature as a significant determinant of health. It follows that important research questions could be posed about the adequacy of individuals' homes both for relationships between household members and for making and maintaining social ties with individuals living outside the household.

Some research has suggested that local social relations may be important determinants of health and arguments have been made for the importance of local social capital in the production of health. Insofar as the relative location of one's home shapes one's access to local social supports and social capital, there may be important health consequences, but the geographic scale at which social capital may influence health is not well understood.

## Political dimensions

Housing quality, availability, and affordability are influenced by public policy. Current Canadian housing policy supports home ownership and ensures the vitality of the housing construction industry (as the heavy emphasis placed on housing starts as an economic indicator suggests). Meanwhile, fiscal retrenchment in the early 1990s led to the near-elimination of new investments in public housing. These developments raise questions about the political power of voices calling for more affordable and public housing.

Political struggles over neighbourhood conditions may also have implications for health. All human activity must occupy space somewhere, including unpopular land uses such as waste disposal facilities or prisoners' half-way houses. Lower socio-economic neighbourhoods typically bear the burden of unwanted land uses, partly because of their inability to resist them. Higher socio-economic neighbourhoods are better able, given their political influence, education, and financial resources, not only to resist unwanted land uses, but also to demand better neighbourhood amenities and insist on the maintenance of those amenities to a higher standard.

## Financial dimensions

It is well-established, but seldom recognized in housing and health research, that housing markets are powerful engines of inequality. Although labour markets are perhaps the principal source of inequality in capitalist societies, land and housing markets also help redistribute wealth and income in a regressive fashion.

The primary distinction is between owner-occupiers and renters. There are several well-understood (but seldom tracked) pathways by which income and wealth are redistributed from owners to renters (such as the capital gains tax exemption for a primary residence and subsidies for home ownership).

Although many studies note the relationship between income and health, wealth is probably a better indicator of a household's socio-economic status, and housing is usually the single most important asset of most households. Yet little has been written on the effects of inequalities in housing wealth on health inequalities.

## Location

A location in space, a place to base one's activities and existence, a place that provides access to goods, services, work, and recreation are important functions of housing. One's home and its immediate environment is likely to be the setting for exposure to a mix of positive and negative influences on health. This may also explain part of the "neighbourhood effects" on health and human development cited in the research literature. Moreover, housing market dynamics confer significant locational advantages upon households in ways that systematically disadvantage households of lower socio-economic status.

### *Promising areas for research*

**Research suggests that local social relations may be important determinants of health. Since the relative location of one's home shapes one's access to local social supports and social capital, housing location may have important health consequences.**

## *5. Results from the consultations*

The questionnaires and stakeholder workshops established needs, gaps, and opportunities for research on the links between housing and health. For example, participants added a further dimension to those listed above – the cultural dimension. Several people mentioned particular issues related to First Nations housing and the challenges immigrants face in acquiring adequate housing.

Some determinants were considered more important than others. Participants agreed that the financial dimension was the most important – as one put it, "Poverty comes before homelessness." However, the largest part of the discussion concerned the social benefits of housing. The political dimension was also discussed in depth by many of the workshop groups – especially issues of power at the community level.

Participants drew attention to a dearth of research information on the housing situation of certain sub-

groups – Aboriginal people, immigrants, single mothers, seniors, families in poverty, mental health consumers. Of particular concern was the Aboriginal population, which is disproportionately represented among the homeless population. Several participants suggested that more information is required on issues of service delivery to this and other sub-populations.

The lack of dissemination of research information was identified as a major area of concern, resulting in a lack of awareness about available research. A Web-based national housing and health information network was the most recommended method of accessing and sharing information.

At all of the workshops, participants expressed interest in creating working partnerships between academia and communities for research on the effects of housing on health status. However, one obstacle to such collaborative research is the competing needs of the two groups. Communities need tangible results such as funds for shelters or training for the unemployed, while academics need to get published in recognized journals. Given these different needs, is real partnership possible?

### *Barriers to collaboration*

**One obstacle to collaborative research between community groups and academics is the competing needs of the two groups. Communities need tangible results such as funds for shelters or training for the unemployed, while academics need to get published in recognized journals.**

Many participants called for better explanations of the concepts and language used by researchers and policy-makers in their reports. Difficulties in reading the lengthy reports were magnified by the "jargon-laden" language in academic and government materials. Many Quebec participants noted that many reports were available only in English.

Participants were also concerned about communicating research results to decision-makers. A common question raised by workshop participants, however, was "Who *are* the decision makers anyway?" Participants also identified the need to bring the media and business community onside as stakeholders. Research needs to articulate the benefits (health, economic, social) of safe, affordable, accessible housing.

Finally, the workshops raised the question of research capacity – not only the capacity to do research, but also to *use* research. Most service providers, where a lot of the existing data is collected, are too busy delivering the services to conduct research. The development of a standardized research methodology module for use by service provider organizations would be a first step towards addressing this shortage of research capacity.

Service provider organizations also need to know how to acquire reliable information about effective practices elsewhere. They are hungry for information on "success stories" and other information about how to better serve their clientele. They typically lack the resources and time to search for this kind of information, and many argued that periodic reports would enhance their ability to translate research findings into practice.

One of the key challenges that emerged from the consultations was the difficulty of maintaining a focus on research questions and data sources. The research team reminded participants that research was not an end in itself, and should have some practical application, but for many of the stakeholders, it was very difficult to articulate issues as research questions. Instead, many of the discussions focused on "What should be done" and "Who should do it," despite efforts by the facilitators to get participants to focus on how to articulate their experiential knowledge into empirical research questions. Ultimately, many participants, despite an interest in what research could provide, acknowledged, "We don't know what we don't know."

## 6. What is needed

The consultations and questionnaire identified the following requirements for research on housing and health.

### Research requirements

- **A baseline inventory of housing stock and housing conditions**, including illegal suites, rented condos, and other data not usually captured by conventional housing statistics.
- **Long-term/longitudinal studies**, which would provide stronger evidence of a relationship between housing and health. As one participant said, "Documented evidence (rather than just anecdotal information) of the benefits of secure, adequate, affordable housing would provide greater ammunition in the lobbying efforts for more social housing programs."

- **"Natural" experiments**. New public and private housing developments open each year, which have to potential to become natural experiments because they represent a change from one housing circumstance to a new housing circumstance, and it is possible to assess residents' health status before and after they move. Residential intervention programs also routinely house new clientele. These examples represent scientific opportunities. If there were some routine data collection, it would be possible to capture the effects of housing interventions on health and health care utilization, and possibly to establish best practices in housing and health.
- **Greater linkage of health data**. Administrative health care utilization data, which is available with the permission of the subjects, could be used for research on the effectiveness (and cost-effectiveness) of housing interventions for vulnerable sub-groups.
- **Performance indicators or benchmarks**. Workshop discussions around the setting of benchmarks led into a discussion of quality of life measures and ultimately how health is measured. There was also much discussion about the current benchmark for housing affordability of no more than 30% of gross income going towards housing. By adopting such a threshold, information about households that spend much less or much more than 30% of income on housing is lost.
- **Outcome-based planning**. Workshop participants suggested building outcome-based planning into future housing research. Outcomes might include increased quality of life; decreased costs to health and justice systems; increased social benefits of adequate housing; increased public awareness; eviction prevention; and an increased "sense of control" over the home environment.
- **Comparative information**. There is a need to engage in comparative analysis of how other jurisdictions have addressed the issues. More research on program evaluation techniques and the development of indicators in the housing and health sector would allow for the comparisons of outcomes.

### Areas for future study

The workshop participants also argued for more investigation in the following areas.

- **Economic aspects of housing and health**, including cost-benefit analyses that would demonstrate the value of housing as a public health investment, and research on household budget decisions involving housing – that is, how money spent on housing is money unavailable for other potentially health-enhancing goods.
- **Research over the life span**, particularly the relationship between housing quality and child development and between housing and seniors' well-being.
- **Integration and social mix**, including the relationship between residential segregation and health and human development outcomes.
- **Physical hazards**, including the societal costs of poor indoor air quality and other physical hazards and the nature and severity of environmental sensitivity disabilities in Canada.
- **Home ownership vs. renting**, especially the social, economic, psychological, and other benefits (or burdens) of home ownership.

## 7. Conclusion

The collaborative stakeholder process revealed considerable interest in strengthening housing and health research among the stakeholders who participated in the regional workshops, as well as those who submitted online questionnaires, and among corporate stakeholders such as the National Housing Research Committee (NHRC) and the Canadian Housing and Renewal Association (CHRA). Despite this keen interest, many needs, gaps and obstacles were identified on the path to a greater concentration of research on housing and health and its translation into policy.

The greatest need is for research capacity. Few academic researchers are focused in this area in Canada, little research activity is taking place in federal or provincial ministries and departments, and most of the organizations that deliver housing services for provincial governments do not have the resources, skills, or time to participate in research.

The Institute of Population and Public Health at the Canadian Institutes of Health Research could play a leadership role in coordinating and disseminating research and strengthening research capacity in this area, working with the Canada Mortgage and Housing Corporation, the National Homelessness Secretariat, and the National Research Committee and the Canadian Housing Renewal Association (the latter representing NGO and local and provincial governments).

### Reference

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