What Role for Housing in Health and Social Care Provision?

Sue Adams
DIRECTOR OF CARE & REPAIR ENGLAND

ABSTRACT
Older people (particularly 75 years+) are the main users of health and social care services. They are also the age group most likely to occupy non-decent homes. Government health and social care policy is increasingly focused on enabling more older people to remain living independently in their own homes and on delivery of care 'at or closer to home'. This article considers how greater recognition of the negative impacts of poor-quality and inappropriate housing on older people's health and well-being, combined with targeted housing repair and adaptation assistance, could contribute to achieving a range of current health and social care objectives, including enabling older people to live independently in mainstream housing and better management of chronic health conditions.

KEYWORDS: HOUSING AND HEALTH AND SOCIAL CARE; OLDER PEOPLE; INDEPENDENT LIVING

Contact details: sueadams@freenetname.co.uk

The policy response to the housing and health connection

The causal links between housing standards and a range of health conditions have been extensively documented, most comprehensively in recent years through the process of creating the Housing, Health and Safety Rating Scheme (HHSRS) (CLG, 2002–3).

The main health conditions with an identified causal link to an aspect of housing have also been summarised clearly in the *Health Risks and Health Inequalities in Housing Assessment Toolkit* (Blackman, 2005). They include respiratory conditions, circulatory illness (ischaemic heart disease and cerebrovascular disease), accidents (falls, burns, carbon monoxide poisoning, electrocution), spread of infectious diseases, mental ill-health (depression, anxiety) and cancers.

One policy response to the identification of causal links between housing conditions and health problems is a systematic programme of improvements to buildings and infrastructure. An early example is the identification of contaminated water as a major carrier of diseases, which (eventually) resulted in the major public works programmes of water treatment and sewage systems. At the other end of the intervention spectrum would be a policy response whereby the state informs the householder of the health risks posed by particular housing conditions but leaves it to the individual to make any alterations or improvements to their home, should they so choose. This is a possible course of action via the current HHSRS.

A 'mid-way' response is to target state-supported housing interventions at those individuals who are most at risk of the health problems which are caused

 © *Pavilion Journals (Brighton) Ltd*

or exacerbated by housing conditions, and who are the least able to carry out the property alterations that could improve an existing health condition or reduce the risks of future health decline.

This latter response is the main focus of this paper, which considers how health sector staff can play a role in identifying at-risk individuals and act as a link to remedial services.

The housing and health connections to demographic change

While poor or unsuitable housing conditions can affect a person's health at any age, the impact on older people is particularly significant, for a number of reasons. Older people are the main users of health and social care services and are three times as likely to be admitted to hospital after coming into Accident and Emergency (DH, 2007b). Forty per cent of the NHS's budget is spent on caring for people over 65 years, and on any given day 65% of hospital beds are occupied by the over-65s (DH, 2007b).

Older people are the age group most likely to have long-term health conditions (including heart disease, diabetes, asthma and other respiratory problems), many of which feature in the list of health conditions that are affected by housing, above. Long-term health conditions account for 55% of GP appointments, 68% of outpatient appointments and 77% of inpatient bed days.

Housing condition and suitability can also have a greater impact on older people's physical and mental health because of the large amount of time older people spend in their home environment. People over 65 years spend more than 80% of their time at home on average, and those over 85 years spend 90% there (CLG, 2007a; Adams & White, 2006). From an international literature search of the evidence for health and social care gain from housing adaptation and improvement, Heywood and Turner (2007) concluded that:

> *There is evidence that the most consistent health outcome of housing interventions is improved mental health.*

This report also identified evidence that depression in older women resulted in a 30% increase in the risk of hip fracture.

The number of people over pensionable age is projected to increase from 11.4 million in 2006 to 12.2 million in 2011 and 13.9 million by 2026, peaking at 15.3 million in 2031 (Shaw, 2004). In 2003 1.9% of the UK's population were aged 85 years and over, and this percentage is projected to rise to 3.8% by 2031 (GAD, 2004). Thus an important factor in the increasing policy focus on cost-effective use of health and social care resources is the ageing of the population and the potential implications that this has for growth in demand for NHS and care services.

Recognition that suitable housing provision for an ageing population could play a role in dealing with this predicted growth in health and social care demands is beginning to emerge. The Government's recent housing strategy for housing in an ageing society (CLG, 2007a) includes a chapter on housing, health and care links.

Around 90% of older people live in general housing stock, whether rented or owned. The remainder live in sheltered housing (5%) and care homes/other (5%) (National Statistics, 2004). In 2005–6, 1.5 million individuals reported having a medical condition or disability that required specially adapted accommodation, of whom 25% were living in a home that did not meet their needs. Eighty-five per cent were over 45 years and over half (55%) lived in owner-occupied accommodation (CLG, annual).

Trends in housing, tenure and stock condition

A radical change has taken place in housing tenure over the past three decades. Owner occupation is now the primary form of tenure, accounting for just over 70% of all households (all ages), compared with only 51% in 1971 (CLG, annual). Among 'younger' retired people owner occupation is closer to 80%, rising to 84% in rural areas (National Statistics, 2004).

Just over half of all low income households are now owner-occupied (CIH/CML, 2007). The latest

English House Conditions Survey (2005) (CLG, 2007a) reveals that there are now more vulnerable households living in private sector housing (3.2m) than in social rented (2.8m) (all standards), and the number of vulnerable people in non-decent private sector homes has risen slightly (by 0.04m). Private rented homes are of the worst standard (41% non-decent), while the majority of non-decent homes are owner-occupied (3.8m).

Fifteen per cent of private sector vulnerable households (470,000) live in homes that fail the decent homes standard on any of the repair, fitness and modernisation criteria (excluding thermal comfort). A third of vulnerable people of 75+ years live in non-decent housing – the worst housed sub-group (Adams & White, 2006).

Thus a picture emerges of a growing number of low-income, 'older old' people living in owner-occupied homes, many of which are in need of repair and adaptation.

A policy shift has taken place over the past decade which increasingly places responsibility for the condition of owner-occupied property on individual home owners. While a multi-billion-pound programme of investment has taken place to bring social rented housing up to a decent standard, a systematic approach to the improvement of non-decent homes occupied by low-income home owners has all but ended in many areas. Alongside the cessation of mandatory home repair grants, there has been a reduction in state support for private sector stock improvement, with a growing expectation by government that increased use of equity release will take place. These trends are set to continue as a result of the 2007 Comprehensive Spending Review and the ending of the Decent Homes Public Service Agreement (HM Treasury, 2007).

Housing, health and social inequality

A number of studies published as part of the *English Longitudinal Study of Ageing* (IFS, 2002) quantify the links between health and inequality. They demonstrate a 'social gradient' in health – the lower a person's social position, the greater the level of ill-health and loss of physical function.

Thus loss of physical function is particularly related to both ageing and social class. One in five of those aged 50 and over, and two in five of those aged 80 and over, reported difficulties with one or more aspects of basic self-care such as washing and dressing (IFS, 2002) and earlier loss of function was linked to category of occupation.

There is large geographical variation for disability-free life expectancy. For men there is an 18-year difference between the worst area (Easington) and the best (Hart), and 16.4 years for women (Merthyr Tydfil vs. Elmbridge) (National Statistics, 2004). This can be linked to social class/occupation category, and the correlation of the location of people with early onset disability with the location of poor quality housing and neighbourhoods is evident.

The suitability of the design of a property, its overall standards and the installation of home adaptations can make a significant difference to the ability of a disabled person to live independently in their own home and remain healthy. Thus the link between health, disability, social class and housing conditions requires a public policy response if demand on the NHS and social services is to be managed effectively.

Trends in health and social care policy

Enabling independence, service personalisation, treating older people with dignity and respect, targeted interventions to prevent health problems and avoid hospital admissions, reducing inequalities and providing care at or closer to home are among the key themes running through a range of health-related policies.

The National Service Framework for Older People (DH, 2001) set out the vision of how older people should be treated by the NHS and a timetable for change. With regard to housing and health, the targets for reduction in falls were particularly relevant.

The Government White Paper, *Our Health, Our Care, Our Say: A new direction for community services*

(DH, 2006b), heralded radical reform for the health sector. It emphasised the importance of shifting resources into prevention, joint health and social care action, tackling health inequalities and care at or closer to home. *The NHS in England: Operating framework for 2007–08* (DH, 2006a) set out priorities for the year, next steps in reform and financial objectives. It stresses the need for PCTs to work with local authorities to improve health and well-being, reduce inequalities and achieve a shift towards prevention.

At the heart of social care policy for older people is the aim of enabling a greater number to remain living independently in their own homes. Many of the documents noted above are equally applicable to the future vision for social care, with the emphasis on prevention and support for independence. The consultation paper *Putting People First: A Shared Vision and Commitment to the Transformation of Adult Social Care* (DH, 2007a) also emphasises independent living, personal control and quality of life. And funding is now following, with the introduction of the Social Care Reform Grant of £520m over the next three years.

What is also needed is a more effective housing response to deal with the condition and suitability of the housing stock that older people are living in.

Measuring the health gain from housing interventions

Part of the rationale for targeting housing resources on particular groups of older people would be to achieve gains in health and social care costs.

This is in line with a culture of cost/benefit analysis in the health sector, which uses such systems for decision making, for example assessing the cost-effectiveness of drugs and particular medical treatments. Unfortunately, there is a more limited body of evidence which clearly costs the financial gains in terms of health and social care expenditure resulting directly from specific housing-based interventions.

Heywood & Turner (2007) concluded that the evidence that increased investment in housing adaptations and equipment would bring significant savings to the NHS and to social services budgets is not complete:

> *and more work is needed to disaggregate the 'multi-factorial interventions' that are known to be effective but not fully understood.*

Some studies have attempted to measure the health gain from housing interventions by taking an area-based approach. For example, analysis of the potential health impact of decent homes improvements on a housing estate in Sheffield (Gilbertson *et al*, 2006) aimed to predict NHS gains using models developed in connection with the HHSRS. However, this approach does not quantify gains in terms of the specific individuals who are most at risk of requiring NHS or care services. An area-based approach to quantifying wider health gain also tends to result in a focus on improvements to social rented housing, where the landlord is responsible for the condition of the housing stock and can thus work with researchers and control the process of improvement.

As noted above, effective targeting of state resources for measurable gain on the highest risk individuals is the favoured health sector approach. The NHS is already applying risk modelling across entire populations, using tools such as PARR and the Combined Predictive Model in order to make predictions about future risk of hospital admission and then intervening 'upstream' in order to prevent such admissions (King's Fund, weblink). Research is now under way to examine the applicability of such modelling to avoidance of care home admission, and early work on this topic (Lewis, 2007) notes that poor housing is one of the known risk factors to be included in the equation.

The potential role of health and social care staff in brokering housing related interventions – a case study

Improved operation across sectors, partnership working, seamless services – these concepts and

ideals have been discussed in the health and social care sectors for nearly two decades. Joint strategic planning, pooled resources, and common targets and objectives across health, social care and all other local services are key threads in government policy.

But is housing in the frame, and do these ideals translate to frontline delivery? Is it possible to turn the rhetoric into reality with regard to holistic assessment of an individual which straddles housing, health and social care within existing structures and roles? What is the scope for targeting housing resources via the health sector? Are front-line staff able and willing to take on this role? What are the potential gains and pitfalls? These were among the questions that the national housing charity Care & Repair England aimed to address through its *Healthy Homes, Healthier Lives* initiative (weblinks below).

Development and delivery of Healthy Homes Assessment cross-departmental training for front-line staff from health and social care professions was one element in this programme. This training package aims to raise awareness of health and housing links among frontline staff in the health, social care, housing and voluntary sectors. It aims to enable participants to identify housing factors which are affecting the health and well-being of their patients and clients, and to instigate remedial action, usually through referral to a specialist source of help such as a home improvement agency, social landlord or housing advice service.

The training has the secondary aims of:

- forging links across professional boundaries in order to encourage and support cross-sector co-operation and referral
- providing the impetus for higher level co-operation between service planners and commissioners by demonstrating the benefits to patients and clients of cross-sector working practices.

The response to the Healthy Homes Awareness training evaluation on the day of delivery was very positive; 88% of participants said that what they had learned was useful (31%) or very useful (57%) to their practice, and that it would enable them to refer clients and patients to other services (87%).

It proved difficult to make contact with the participants one year after the training. This exercise in itself revealed a high rate of staff turnover and communications problems within PCTs. However, of those who were reached and who did respond (41 health and care staff), the majority reported that they took more notice of people's housing conditions (78%), were more likely to refer people on to other services (83%) and that some of their clients' and patients' housing conditions had been improved as a result (44%). Respondents were not able to provide exact numbers of the people whose housing conditions had been improved as a result of their intervention, but illustrative case examples (***Table 1***, below) were obtained.

Data on overall trends in referral sources to HIAs provided by foundations revealed that levels

Table 1: PCTS, SOCIAL SERVICES & POPP STAFF: IMPACT ON PRACTICE ONE YEAR AFTER TRAINING

Question	Affirmative
No change: I already noticed aspects of people's housing conditions	22%
It made a difference: I take more notice of housing conditions now	78%
I found out about services I didn't know about before	93%
No difference: I already knew about the help the training covered	5%
Training had no impact on working practice	15%
I am more likely to refer clients/patients to other services	83%
Some of my clients' housing and living conditions have improved	44%
The training has made no difference to the individuals that I work with	27%

 © *Pavilion Journals (Brighton) Ltd*

of referral from the health sector are low, but a comparison of referral sources during the periods before and after Healthy Homes training shows a higher rate of increase in the number of health sector sources than in non-trained areas.

The picture that emerged from the telephone interviews was mixed. Where a local champion had taken up Healthy Homes ideas and promoted them extensively, some changes in working practice could happen, but in all cases it was the HIA who had championed the issue, rather than a health sector officer. This was the experience of the original Healthy Homes model pioneered in Bristol, where a rolling programme of Healthy Homes training is now well established. In most areas, information was not passed on within the PCT, and the training had not resulted in systematic changes to cross-sector working. One community matron had organised Healthy Homes training for a group of community matrons. Her experience reflects much of the feedback from health and social care staff about the impact of constant organisational change on service development.

> *'We were very interested and excited by the course and I wanted to organise more sessions – I am sure that awareness of housing is an essential part of what we aim to achieve in helping people stay healthy and safe in their communities. But since then everything has been in upheaval. Everybody was on a temporary contract, there have been arguments and unsettlement. Next week everybody has to undergo interviews to keep their jobs. Obviously this has affected staff profoundly. A lot of the team take time off sick with stress and they are not in the mood for developing new ideas.'*

Conclusions

There is extensive evidence of the impact of housing on a range of health conditions, particularly the chronic conditions that many older people experience. Good-quality, suitable housing can therefore have a significant impact on health and well-being in later life.

An important driver for a policy and practice response to the links between housing, health and demographic change is the recognition that failure to address housing defects and inadequacies can result in higher costs to the state via higher demand for health and social care interventions. However, there is a lack of cost/benefit analysis and impact assessment of specific interventions for the individuals who are most at risk of requiring NHS treatment or social care – those who could place the highest demands on health and care. Further research is needed to address this gap.

Increased targeting of help with housing repair, improvement and adaptation where it will have the greatest impact on preventing the need for health and social care is strongly anticipated as resources become more stretched. However, there are real questions about how these links will be made effectively.

The experience of working with frontline health and social care staff through the Healthy Homes initiative reveals that there is a significant gap between the reality on the ground and the ideals of cross-sector working, comprehensive assessment of needs and joining up services to achieve the common goals of enabling older people to live independently with better health and well-being.

Changing established working practices and breaking down professional barriers is never easy. The Healthy Homes initiative has shown that it is possible for frontline health and social care staff to learn to identify shortcomings in housing conditions and instigate remedial action, with resulting gains for older people. However, most individuals will not automatically incorporate this approach into their day-to-day practice. Support for significant changes to working practice will also have to come from higher-level change which values staff taking a different approach to working across conventional professional boundaries. Training the next generation of community health and social care sector staff to take a broader view of their role may also help in this process of change.

However, it would seem that, for the foreseeable future, housing-related service providers, such as home improvement agencies and environmental health, will still need to take a leading role in addressing the conditions in mainstream housing that have an impact on older people's health.

References

Adams S & White K (2006) *Older People, Decent Homes and Fuel Poverty: An analysis based on the English House Conditions Survey*. London: Help the Aged.

Blackman T (2005) *Health Risks and Health Inequalities in Housing: An assessment tool*. London: Housing LIN.

CIH/CMI (2007) *UK Housing Review*. London: Chartered Institute of Housing and Council for Mortgage Lenders.

CLG (2002–2003) *Statistical Evidence to Support the Housing Health and Safety Rating System Volumes I, II, III*. London: Communities and Local Government.

CLG (2007a) *English House Conditions Survey*. London: Communities and Local Government.

CLG (2007b) *Lifetime Homes, Lifetime Neighbourhoods*. London: Communities and Local Government.

CLG (annual) *Survey of English Housing*. London: Communities and Local Government.

DH (2001) *The National Service Framework for Older People.* London: Department of Health.

DH (2006a) *The NHS in England: Operating Framework for 2007–08*. London: Department of Health.

DH (2006b) *Our Health, Our Care Our Say*. London: Department of Health.

DH (2007a) *Putting People First: a shared vision and commitment to the transformation of Adult Social Care.* London: Department of Health.

DH (2007b) *A Recipe for Care – Not a Single Ingredient*. London: Department of Health.

Gilbertson J, Green G & Ormandy D (2006) *Decent Homes, Better Health*. Sheffield Hallam University.

GAD (2004) *2003 Principal Projections*. London: Government Actuary Department.

Heywood F & Turner L (2007) *Better Outcomes, Lower Costs: Implications for health and social care budgets of investment in housing adaptations, improvements and equipment: a review of the evidence*. London: Office for Disability Issues and University of Bristol.

HM Treasury (2007) *2007 Pre-Budget Report and Comprehensive Spending Review*. London: HM Treasury.

IFS (2002) *English Longitudinal Study of Ageing*. London: Institute for Fiscal Studies.

King's Fund: www.kingsfund.org.uk/current_projects/predictive_risk/patients_at_risk.html.

Lewis G (2007) *Predicting Who will Need Costly Care*. London: King's Fund.

National Statistics (2004) *General Household Survey 2002*. London: Stationery Office ONS.

Shaw C (2004) Population trends 118. Winter 2004. *Interim 2003-Based National Population Projections for the UK and Constituent Countries*. London: National Statistics.

Related resources

Healthy Homes, Healthier Lives (2007) [CD-Rom/DVD] London: Care Services Improvement Partnership. www.icn.csip.org.uk/housing.

Healthy Homes, Healthier Lives. Weblink to training materials: www.careandrepair-england-hhhl.org.uk/index.htm.

 © *Pavilion Journals (Brighton) Ltd*