

Better Homes Better Health



Health Impact Assessment of Sheffield's Housing Strategy

Geoff Green · Paul Pugh

Foreword

In the last ten years Sheffield has regenerated; investor confidence is returning to the city and real progress has been made in transforming our homes and neighbourhoods. Health in Sheffield has also improved dramatically, with life expectancy now on a par with the national average and people living longer than ever before.

However, progress has not been even and the health and well-being of people in Sheffield is characterised by sharp contrasts. We know there remain key challenges in tackling health inequalities, reducing social exclusion, meeting the needs and aspirations of an ageing population and empowering people to live independent lives for longer. We also know that we will only achieve sustained improvements in these areas if we tackle the root causes of poor health and well-being.

As a World Health Organization (WHO) Healthy City we are committed to putting health and well-being at the heart of decision making and addressing the social, economic and environmental factors that determine people's health. This Health Impact Assessment has been commissioned by the Sheffield First for Health and Well-Being Partnership in recognition of the important contribution quality homes and neighbourhoods have to play. It is intended to support our city in enhancing the positive contribution that our Housing Strategy makes to realising our ambition of achieving good health and well-being for all our communities.

Georgina Parkin; Housing Strategy Manager, *Maura Branney*, Healthy City Co-ordinator, Sheffield City Council, *Kieron Williams*, Health and Well-Being Partnership Manager, *Louise Brewins*, Sheffield PCT; for the *Sheffield First for Health and Well-Being Partnership*.

Executive summary

Messages

- *For the majority of residents the housing market provides a secure home, conferring the psychosocial benefits of mental health and well-being.*
- *For a minority of residents, stress arising from the financial insecurity of their home leads to depression and anxiety.*
- *A warm, safe and secure home contributes to residents' health and well-being.*
- *Cohesive communities and good quality housing environments contribute to sustainable neighbourhood health and well-being.*
- *Strategic planning and investment in housing services promote the independence of vulnerable residents and alleviates physical dependency caused by ill health.*
- *Safer neighbourhoods and social support in the home will promote mental health and well-being.*

Recommendations

- *Access: Maintain and replenish a strong social housing sector to enhance the financial security and mental health of lower income residents.*
- *Affordability: Short term focus on measures to alleviate financial distress in the private housing market and maximise gains in mental health.*
- *Housing Quality: Cost-effective investment to improve health should focus on measures to improve security and warmth in private rented housing and in single pensioner households of all tenures.*
- *Neighbourhoods: A holistic model of successful neighbourhoods should balance environmental objectives with those for health, social cohesion and community safety.*
- *Independence: Expand Sheffield's Joint Strategic Needs Assessment to include a cost-benefit analysis of housing's contribution to adding quality of life to years lived.*
- *Inclusion: Provide evidence of health gain from securing a home for vulnerable and excluded people.*

Introduction

Housing is one of the wider determinants of health acknowledged by the *Sheffield First Partnership*¹ and daughter, *Sheffield First for Health and Well-Being*. The holistic approach of Sheffield's *Housing Strategy*² leads naturally to this overview of potential health benefits for Sheffield's population. The scope of our Health Impact Assessment (HIA) is broader than our earlier assessment of the *Decent Homes Programme*³ for Sheffield's stock of council housing, encompassing here all tenures and every neighbourhood.

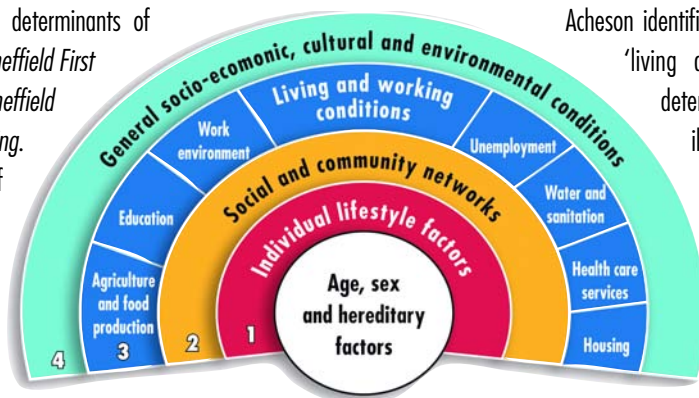


Figure 1: **Social model of health**

Acheson identifies housing as one of the six key 'living and working conditions' which determine health outcomes, for good or ill. However over the past 30 years the spotlight has moved away from the physical health benefits of replacing slums with new municipal housing. Nowadays the focus is on social cohesion, mental health and the role of housing in promoting independence in the growing number of older, often disabled citizens.

This summary report is structured by the three main components of the *Strategy* report, (**Section 2**) Successful housing markets (**Section 3**) Successful neighbourhoods and (**Section 4**) Independence and inclusion. Each section reviews the scientific evidence of potential health impacts, and then applies this evidence to the strategic interventions proposed.

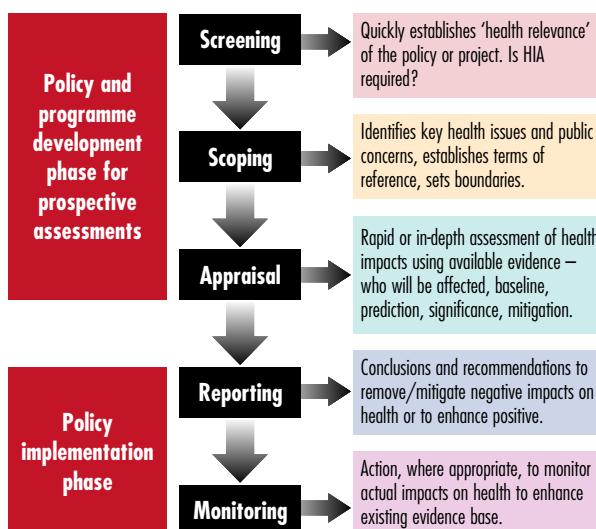
Method

Having 'Screened' (figure 2) the health relevance of the *Strategy* in a brainstorming session of officers from the Housing Department and Primary Care Trust, this commission moves on to the second, 'Scoping' stage of HIA procedure identified by the World Health Organization.

Why health?

Sheffield's health is *not* essentially the product of the National Health Service. Instead it is largely determined by the combination of 'upstream' and 'downstream' factors summarised in the *Independent Inquiry into Inequalities in Health* chaired by England's former Chief Medical Officer for Health.⁴ His scientific report is based on a social model of health (figure 1) which 'shows the main determinants of health as layers of influence one over another.'

Figure 2: **HIA procedure: the five stages**



Source: World Health Organization: <http://www.who.int/hia/tools/en/>

Our review is not comprehensive. Given limited time and resources our approach at this stage is to highlight evidence and identify key health issues arising from the *Strategy*. The report is presented in short, accessible format to encourage debate with stakeholders in Sheffield City Council's Housing Service and partners of *Sheffield First for Health & Well-Being*.

¹ Housing Strategy & Policy Team (2007) *Housing in Sheffield, 2007-2010*. Sheffield City Council.

² Sheffield First Partnership. (2005) *Sheffield's Future; be part of it: Sheffield City Strategy 2005-10*. Sheffield City Council.

³ Jan Gilbertson, Geoff Green, David Ormandy (2006) *Decent Homes, Better Health: Sheffield Decent Homes Health Impact Assessment*. Centre for Regional Economic and Social Research, Sheffield Hallam University.

⁴ Donald Acheson. (1998) *Independent Inquiry into Inequalities in Health Report*. The Stationery Office. London.

Successful housing markets

Potential health impacts

Key message 1: For the majority of residents the housing market provides a secure home, conferring the psychosocial benefits of mental health and well-being.

Key message 2: For a minority of residents, stress arising from the financial insecurity of their home leads to depression and anxiety.

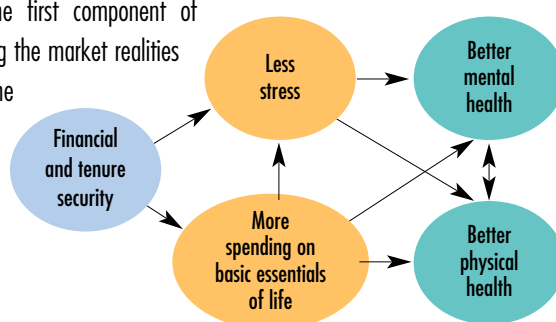
‘Successful Housing Markets’ are the first component of Sheffield’s *Housing Strategy*. Embracing the market realities of 21st Century housing provision in the UK, the Strategy goes beyond the traditional focus on municipal housing by including all tenures.

Health revolution

The market focus of the *Strategy* reflects a new pattern of illness and health. Lifestyle illnesses such as cancer and heart disease have displaced the infectious diseases spread by slum housing conditions. Mental health problems now account for 20% of disease, affecting 1 in 6 residents at any one time.¹ The next section will address the specific influence of crime and fear of crime on mental health. Here is a look at the wider psychosocial benefits of a secure housing base.

A secure base

To what extent do housing markets contribute to the mental health and well-being (as well as the material benefits) enjoyed by the great majority of Sheffield residents? Research is at the philosophical stage of development. Antony Giddens, the eminent sociologist has popularised the concept of ‘ontological security’ – a sense of security and identity in an uncertain world.² Peter Saunders identifies the home and above all, owner-occupation as conferring control and ‘ease in the deepest psychological sense.’³ However Glasgow researchers reveal a



nearly equal proportion of social tenants (about 80%) also regard their home as (a) giving them control over their environment and (b) providing a haven.⁴

Do these psychosocial benefits impact on mental health? R.D. Laing, the famous Scottish psychiatrist, maintains that ‘ontological security’ is a prerequisite for psychological health and many instances of mental health result from a basic insecurity.⁵ There is evidence from Vancouver showing how health, especially mental health, results from housing as ‘a good location for life,’ free of the strain of high housing costs and worries about being forced to move.⁶

The downside

There is more substantial evidence of the impact of insecure housing on mental health, much of it derived from an earlier period of stress in the UK housing market. Sarah Nettleton and Roger Burrows show how mental health problems are linked to financial stress associated with marginal owner-occupation.⁷ Mark Taylor highlights the psychological costs of mortgage arrears⁸ and Burrows and Nettleton investigate the psychological distress caused by extreme cases of mortgage possession.⁹ Peter Ambrose shows how high housing costs in all tenures erode resident’s quality of life by limiting the affordability of other basic essentials of life.¹⁰

¹ Office of National Statistics (2000) *Psychiatric morbidity among adults living in private households in Great Britain*. ONS. London.

² Antony Giddens (1991) *Modernity and Self Identity: Self and Society in the Late Modern Age*. Polity Press, Cambridge.

³ Peter Saunders. (1990) *A Nation of Home Owners*. Unwin Hyman. London.

⁴ Ade Kearns, Rosemary Hiscock, Ann Ellaway & Sally Macintyre. Beyond Four Walls. The Psychosocial Benefits of Home: Evidence from West-Central Scotland. *Housing Studies*. 2000. Vol.5 Number 3; pages 387- 410.

⁵ RD Laing (1960) *The Divided Self: An Existential Study of Sanity and Madness*. Harmondsworth Penguin.

⁶ Jim Dunn (2002) Housing and inequalities in health: a study of the socioeconomic dimension of housing and self reported health from a survey of Vancouver residents. *Journal of Epidemiology and Community Health*. Vol. 56. Pages 671-81.

⁷ Sarah Nettleton & Roger Burrows. Mortgage debt, insecure home ownership and health: an exploratory analysis. *Sociology of Health and Illness*. 1998. Vol. 20. Number 5. Pages 731-753.

⁸ Mark Taylor, David Pevalin & Julia Todd. The psychological costs of unsustainable housing commitments. *Psychological Medicine*. 2007. Volume 37: pages 1027-1036.

⁹ Sarah Nettleton & Roger Burrows. When Capital Investment Becomes an Emotional Loss: The Health Consequences of the Experience of Mortgage Possession in England. *Housing Studies*, 2000. Vol 15. Number 3, pages 463-479.

¹⁰ Peter Ambrose. (June 2007) High Price to Pay. Roof. Shelter.

Successful housing markets

Strategic intervention

Recommendation 1: Access: maintain and replenish a strong social housing sector to enhance the financial security and mental health of lower income residents.

Recommendation 2: Affordability: focus short term on measures to alleviate financial distress in the private housing market and maximise gains in mental health.

To the extent that Sheffield's *Housing Strategy* promotes successful housing markets, then mental health is enhanced and psychosocial stress avoided. Health benefits derived from home as a 'haven' are maintained by financial and tenure security. Limited supply is the biggest barrier to **accessing** the security provided by social housing. In the private sector **affordability** is the biggest barrier to security (figure 4).

Accessing the Social Sector

With long term tenancies and state subsidised rents, social housing provides a high level of security, making it the tenure of choice for many on low incomes. Demand far outstrips supply, restricting access primarily to workless households in receipt of state benefits, often caused by poor health. The health of those denied access suffers either because they are overcrowded¹ or in insecure accommodation. Lack of space can cause family conflict, turning a home from 'haven' to 'hell.'² Successful entrants and longer term tenants should experience health benefits, partly offsetting their poor health status.

The *Strategy* supports new building social rented housing under the *National Affordable Housing Programme*, usually as part of regeneration initiatives in the poorer districts of Sheffield. However, the net available stock of social housing will fall because of continuing sales through the Right to Buy Scheme. A shortage of larger houses with gardens will exacerbate family stress leading to further deterioration in the health of the Sheffield's lowest income groups.

Affording private housing

The *Strategy* devotes little space to the growing private rented sector (the least secure tenure) and is cautious about schemes to extend the dominant owner-occupied market to marginal entrants. Shared equity is the preferred model to encourage households on intermediate incomes to buy – discounted sales, shared ownership – in line with the government's National Affordable Housing Programme.

A sustainable market will enhance both the health of established owner-occupiers and new entrants benefiting from affordable housing initiatives. However, the 'Credit Crunch' highlights the downside for marginal owner-occupiers. Repossession claims issued in Sheffield are running at a rate of 1300 annually³ with a significant additional percentage of mortgagors experiencing financial and psychological stress.

Costs and benefits

Many of the 3500 households accessing a secure social housing tenancy each year were previously living in insecure or overcrowded accommodation, and should experience significant mental health benefits. In the private sector, similar health benefits should accrue in the medium term to the projected 300 new entrants annually into affordable owner-occupation. Running at £1/3 million annually, the Housing Aid Service helps alleviate the psychological distress of 1500 financially vulnerable owner-occupiers and private sector tenants.

Figure 4: Sheffield Household Tenure

Tenure	No H/H in Sheffield	Basic security	Strategy focus
Social rent	60k	High	Access
Private rent	31k	Low	Affordability
Owner-occupy	140k	High	Affordability

Source of tenure split in Sheffield: Housing Market Assessment. (2007)

¹ Office of the Deputy Prime Minister (2004) *The Impact of Overcrowding on Health and Education; A Review of Evidence and Literature*. ODPM. London.

² Christine Oldman & Bryony Beresford. Home Sick Home: Using the Housing Experiences of Disabled Children to Suggest a New Theoretical Framework. *Housing Studies*. 2000. Volume 15, Number 3. page 437.

³ Ministry of Justice (August 2008) *Statistics on mortgage and landlord possession actions in the county courts – first quarter 2008*. Ministry of Justice Statistics bulletin.

Successful neighbourhoods

Potential health impacts

Key message 1: A warm, safe and secure home contributes to residents' health and well-being.

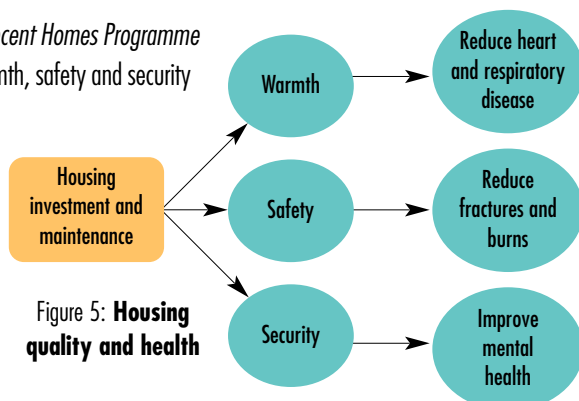
Key message 2: Cohesive communities and good quality housing environments contribute to sustainable neighbourhood health and well-being.

Good quality housing is at the heart of a complex dynamic which defines 'Successful Neighbourhoods,' the second component of Sheffield's *Housing Strategy*.¹ Health is both cause and effect of sustainable neighbourhood development.¹

Quality housing

Our HIA of Sheffield's *Decent Homes Programme* forecast² improved warmth, safety and security for 42,000 Council tenants and their households. However, the health benefits of raising housing standards apply across all tenures. Elderly widows in old

owner-occupied houses are more likely to suffer heart failure because of cold conditions.³ Respiratory problems are more likely in children suffering damp conditions in private multi-occupied housing.⁴ The Government's *National Service Framework for Older People*⁵ cites falls as a major cause of disability and death of older people. The *British Crime Survey* reveals how over 80% of victims are emotionally affected by burglary – 20% suffering from anxiety or depression.⁶



Dynamic neighbourhoods

The *Strategy* highlights Quality of Place 'Outside of all our front doors in the shared places where we live our community lives.' There is evidence that social cohesion, security and environmental quality (including the overall quality of the housing stock) all contribute to better physical and mental health.

Social epidemiologists, Kawachi and Berkman provide evidence⁷ of a generic link between social capital, social cohesion and health. Our studies show links at a neighbourhood level between mental health and (a) social capital⁸ (b) feelings of safety outside the home.⁹ A Swedish study¹⁰ demonstrates a lower risk of heart attack in neighbourhoods with higher levels of safety and cohesion.

Considering neighbourhood environment, scientists and Environmental Health Officers have traditionally focussed on the impact of air pollution on health, now well documented.¹¹ Recent reviews have emphasised psychosocial and lifestyle aspects. The RSPB¹² highlights the impact of green spaces on mental health and England's Chief Medical Officer¹³ enumerates the physical health benefits of exercise encouraged by an attractive public realm.

¹ Geoff Green, Michael Grimsley & Bernard Stafford (2006) *The dynamics of neighbourhood sustainability*. Policy Press. Joseph Rowntree Foundation. York.

² Jan Gilbertson, Geoff Green & David Ormandy. (2006) *Decent Homes, Better Health; Decent Homes Health Impact Assessment*. Sheffield Hallam University.

³ Paul Wilkinson et al, Vulnerability to winter mortality in elderly people in Britain: population based study. *British Medical Journal* (2004) Volume 329, page 647.

⁴ University of Warwick/London School of Hygiene & Tropical Medicine (2003) *Statistical Evidence to Support the Housing Health and Safety Rating System*. Vol.2. ODPM. London.

⁵ Department of Health (2001) *National Service Framework for Older People*. DH. London.

⁶ Nicholas S & Wood M. (2003) Chapter 4. Property Crime in England & Wales. *Crime in England & Wales, 2002/3*. Home Office. London.

⁷ Kawachi I & Berkman LF. (2000) Social capital, social cohesion and health, in Berkman LF & Kawachi I (eds) *Social Epidemiology*. Oxford University Press. Oxford.

⁸ Jan Gilbertson, Geoff Green, Michael Grimsley & Julie Manning (2005) *The dynamic of social capital, health and economy: The impact of regeneration in South Yorkshire coalfield communities*. Sheffield Hallam University.

⁹ Roger Critchley, Jan Gilbertson, Geoff Green & Michael Grimsley (2004) *Housing investment and health in Liverpool*. Sheffield Hallam University.

¹⁰ Chaix B, Lindstrom M, Roswal M & Merlo J (2008) Neighbourhood social interactions and risk of acute myocardial infarction. *Journal of Epidemiology and Community Health*. Vol. 62. pages 62-68.

¹¹ Katsouyanni K, Toulami G, Spix C et al (1997) Short term effects of air pollution and mortality in 12 European cities: Results from time series data from the APHEA project. *Air Pollution and Health: A European Approach*. British Medical Journal. Vol. 314. pages 1658-63.

¹² William Bird (2007) *Natural Thinking: Investigating the links between the natural environment, biodiversity and mental health*. Royal Society for the Protection of Birds.

¹³ Liam Donaldson (2004) *At least five a week: Evidence on the impact of physical activity and its relationship to health*. Sheffield HIA SuNe 1.doc

Successful neighbourhoods

Strategic intervention

Recommendation 1: Cost-effective investment to improve health should focus on measures to improve security and warmth in private rented housing and in single pensioner households of all tenures.

Recommendation 2: A holistic model of successful neighbourhoods should balance environmental objectives with those for health, social cohesion and community safety.

The *Strategy* proposes raising housing standards as key to successful neighbourhoods, then identifies improvements in the environment and community infrastructure. Health benefits flow from these measures, contributing to a virtuous cycle of sustainable development.¹

Housing conditions

Our previous report forecast major health benefits from the £700 million *Decent Homes Programme* to improve 40,000 council dwellings. Now there is more scope for enhancing the health of residents in the private sector. Why?

For two reasons. First, though national statistics² reveal a similar proportion of non-decent owner-occupied dwellings, the sector's dominant size means more residents are affected. Second, a higher proportion (50%) of private rented properties is non-decent. The Private Sector Housing Team confirms a concentration of hazards here. Applying national proportions to the Sheffield stock means 47,600 non-decent homes in owner-occupation and 15,500 privately rented. A council survey in 2008/9 will affirm the proportion.

Security measures — especially 'Secured by Design' windows and doors — are cost-effective in improving mental health in private rented properties with high burglary rates.³ Safety measures will prevent a

modest number of falls. Measures improving energy efficiency should have a bigger impact (than in the social sector) on heart and respiratory disease because (a) baseline energy efficiency is lower, and (b) excess winter deaths are as prevalent in prosperous areas of the city.⁴ Warm Front is a cost-effective grants regime.⁵ Equity loans to owner-occupiers minimise cost to the public purse.

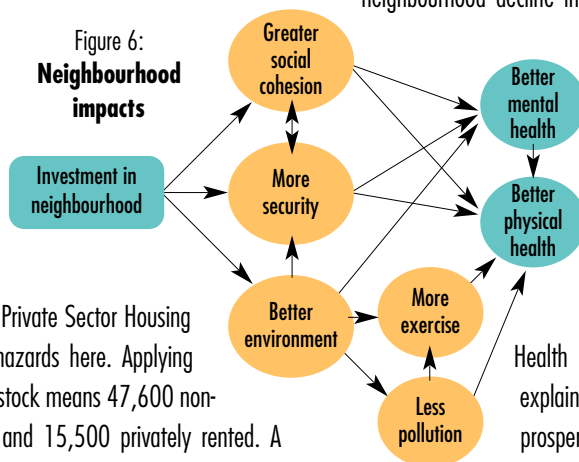
Neighbourhood investment

The *Strategy* focuses on improving 'quality of place' and 'local liveability factors.' We show all of these will help reverse neighbourhood decline in Sheffield's poorest communities.⁶ As the

Strategy proposes, investing in schools, local facilities and the public realm, attracts and retains higher income residents who could opt to live elsewhere. Social capital and community safety are also key retention factors.

Health is crucial in this neighbourhood dynamic explaining the enduring gap between Sheffield's prosperous and deprived areas. Unhealthy people tend to have low incomes, gravitating to deprived neighbourhoods where poor 'liveability' is reflected by lower housing costs. Then they experience an additional 'neighbourhood effect.' Air pollution⁷ and deprivation⁸ impact more on the health of lower income residents.

Figure 6:
Neighbourhood impacts



¹ Llewlyn Davies Young. (2006) *Quality of Place: The North's Residential Offer*. Phase I Report. The Northern Way Sustainable Community Team.

² Department for Communities and Local Government. (January 2008) *Housing Surveys Bulletin*. DCLG. London.

³ Nicholas S., Povey D., Walker A & Kershaw C (2005) (Table 4.01) Crime in England & Wales 2004/5. *Home Office Statistical Bulletin*, National Statistics. London.

⁴ Ashley King. (2008) *Excess Winter Mortality in Sheffield, 2002/3 – 2006/7: Statistical Report*. Sheffield Primary Care Trust.

⁵ Geoff Green & Jan Gilbertson. (2008) *Warm Front, Better Health; Health Impact Evaluation of the Warm Front Scheme*. CRESR. Sheffield Hallam University.

⁶ Geoff Green, Michael Grimsley & Bernard Stafford (2006) *The dynamics of neighbourhood sustainability*. Policy Press. Joseph Rowntree Foundation. York.

⁷ M. Jerrett et al (2004). *Do socioeconomic characteristics modify the short term association between air pollution and mortality? Evidence from a zonal time series in Hamilton, Canada*. *Journal of Epidemiology and Community Health*. Volume 58: pages 31-40.

⁸ K. Sundquist, M. Malmstrom & SE Johansson. (2004) Neighbourhood deprivation and incidence of coronary heart disease: a multilevel study of 2.6 million women and men in Sweden. *Journal of Epidemiology and Community Health*. Vol.58: pages 71-77.

Independence and inclusion

Potential health impacts

Key message 1: Strategic planning and investment in housing services promote the independence of vulnerable residents and alleviates physical dependency caused by ill health.

Key message 2: Safer neighbourhoods and social support in the home will promote mental health and well-being.

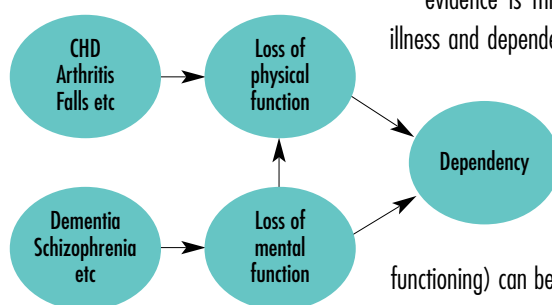
'Independence and inclusion' is the third component of Sheffield's *Housing Strategy*. Good quality homes are a haven contributing to the health and well-being of vulnerable or excluded people. Specifically, lifetime or adapted homes promote independence by mitigating the impact of illness and dependency.

Illness and disability

Just as health promotes independence, so illness is the main cause of dependency (figure 7). Though illness need not cause disability, the 2001 Census revealed 100,000 Sheffield residents with *limiting* long term illness. The majority of these are older people highlighted in the *Strategy* and often the focus of scientific evidence.

Musculoskeletal disease (such as arthritis) is the commonest physical cause of dependency in the elderly, followed by heart and lung conditions and failing sight.^{1 2} Falls in the home are a big cause of fracture, with 1000 hospital admissions annually in Sheffield.³ A minority of the estimated 100,000 Sheffield residents (aged between 16-64) with mental health problems⁴ will require support as will smaller numbers with serious psychiatric conditions and predominantly older people with dementia.

Figure 7: Illness and dependency



Disability trends

Service planners may assume that Sheffield's ageing population will bring about higher levels of disability. However, the scientific evidence is mixed. Pessimists predict a general increase in illness and dependency⁵, especially because age-prevalence rates for specific illnesses like dementia are not projected to fall. On the other hand, optimists in the USA forecast a 'compression of morbidity'⁶ and show that disability (especially poor mental functioning) can be reversed and dependency reduced.⁷

Dependency

Disability need not lead to dependency. For any given level of disability, both social services and housing have a critical role in reducing dependency and promoting independence (as measured by ability to perform activities of daily living ADL⁸). Applying national prevalence rates⁹ there are probably 3000 individuals in Sheffield with a medical condition or disability requiring but not yet benefiting from specially adapted accommodation to enable them to lead more independent lives. The national trend is stable, but these continuing high levels of dependency are not inevitable. In future Sheffield can do better with focused strategic investment in a supportive physical and social home environment.

¹ DN. Kaye. (1989) Ageing of the population: Measuring the Need for Care. *Age and Ageing* Vol.18; pages 73-76.

² Hannes Staeheln. (2005) Promoting Health and Wellbeing in later life, in Malcolm Johnson (ed.) *The Cambridge Handbook of Age and Ageing*. Cambridge University Press.

³ Derived from Hospital Episode Statistics (HES) Department of Health and accessed via the Yorkshire and Humber Public Health Observatory.

⁴ Sheffield PCT/City Council. (April 2008) *Sheffield's Joint Needs Assessment*. SCC/PCT. Sheffield.

⁵ Christina Victor. The Epidemiology of Ageing in Malcolm Johnson (ed.) *The Cambridge Handbook of Age and Ageing*. Cambridge University Press.

⁶ Vicky Freedman, Linda Martin & Robert Schoen (2002) Recent trends in disability and functioning among older adults in the United States. *Journal of the American Medical Association*. Vol. 288 (24) pages 3137-3146.

⁷ Susan Hardy & Gill Thomas. (2004) Recovery from Disability among Community-Dwelling Older Persons. *Journal of the American Medical Association*. Vol. 291(13) pages 1596-1602.

⁸ ADL measures functional ability to perform daily tasks such as lifting, walking, washing and dressing; developed originally by Katz S., et al (1963) Studies of Illness in the Aged: A Standardised Measure of Biological and Psychological Function. *Journal of the American Medical Association*. Vol. 185 pages 914 – 919.

⁹ Department of Communities and Local Government (2008) *Housing in England 2006/7* (Part 1). DCLG.

Independence and inclusion

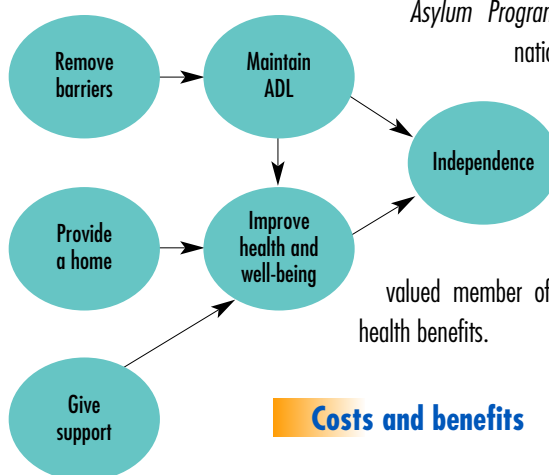
Strategic intervention

Recommendation 1: Independence: expand Sheffield's Joint Strategic Needs Assessment to include a cost-benefit analysis of housing's contribution to adding quality of life to years lived.

Recommendation 2: Inclusion: provide evidence of health gain from securing a home for vulnerable and excluded people.

Sheffield City Council has developed a new role shaping housing development in the city. No longer a direct provider of mainstream housing management services, the inclusion chapter of its *Housing Strategy* focuses on three key areas of activity – (1) Housing Independence (2) Housing Solutions and (3) an Asylum Programme. Figure 8 shows health and well-being as integral to them all.

Figure 8: **Promoting independence**



alcohol problems and those who are homeless. The *Asylum Programme* team supports refugees, EU nationals as well as asylum seekers. All these groups (with their high prevalence of mental health problems) will benefit from simply securing place to stay – where home is a haven. Becoming a valued member of a community brings even greater health benefits.

1. Housing Independence

With a revenue budget of £24 million a year and a £30 million capital programme of new-build over the next few years, the *Supporting People* programme is key to promoting housing independence. The focus is residents made vulnerable by age or disability. Care in the community is firmly established as the preferred option for these vulnerable people, requiring holistic integration of housing with health and social services. The special contribution of Housing Services is to help provide and maintain a home designed or adapted to overcome functional impairment; facilitated by *Disabled Facilities Grant* or the more cost-effective Equity Loans Scheme.

Costs and benefits

Despite new forecasting systems,^{1 2} it is difficult to estimate the potential for improving the health and independence of disabled residents. Probably fewer than the 100,000 Sheffield residents reporting long term limiting illness are in the frame, but more than the 15,000 currently helped by the *Supporting People Programme* or the 8000 annually who receive adaptations or equipment to enhance their Activities of Daily Living. Adaptations are cost-effective; £6000 providing for a severely disabled wheelchair user will typically save £400,000 in residential care costs.³ The Equity Loan Scheme for such improvements reduces costs to the public purse as well as mobilising trapped resources for the families concerned.

2 & 3. Housing Solutions & Asylum

The *Housing Solutions* team works to prevent homelessness and secure decent accommodation for vulnerable people – young people leaving institutional care, families with chaotic lifestyles, people with drug or

It is difficult to estimate the costed health benefits of the service to promote inclusion of vulnerable people. They suffer mental distress and physical illness⁴ but there is little systematic evidence on the extent of their recovery when re-housed. Further research is required.

¹ *Projecting Older People Population Information System* CSED/CSIP 2008.

² British Medical Association (2000) *Asylum Seekers: Meeting Their Health Care Needs*. BMA Publications Unit.

³ Frances Heywood & Lynn Turner (2007) *Better Outcomes: Lower Costs; Implications for health and social care budgets of investing in housing adaptations, improvements and equipment – a review of the evidence base*. Office of Disability Issues. Department of Work and Pensions. London.

⁴ Donald Acheson (1998) *Independent Inquiry into Inequalities in Health Report*. The Stationery Office. Department of Health. London.

Conclusion

Besides a general duty to promote the health and well-being of Sheffield's population,¹ Sheffield City Council has powers to influence living conditions which critically determine certain aspects of physical and mental health. Our previous HIA of the *Decent Homes Programme* was limited to the Council's housing stock. This HIA encompasses a much bigger topic, giving an overview of the current impact and potential of the Council's overarching *Housing Strategy*.

We conclude that all three main components of the *Strategy* can make a positive impact, as shown in figure 9. **First**, *Successful Housing Markets* have their biggest impact on mental health by promoting a sense of identity and security in an uncertain world. **Second**, good quality housing is key to *Successful Neighbourhoods*, promoting both physical and mental health. **Third**, housing contributes to the *Independence and Inclusion* of vulnerable residents, promoting health by providing a haven.

Evidence

Clearly within the timeframe and resources available we could not directly survey the health outcomes of specific programmes and projects within the *Strategy*. So our method was first to synthesise or 'triangulate' evidence of health impacts from a variety of credible sources, then apply the results to the three components of the *Strategy*.

However, there are caveats. Though there is a substantial body of negative evidence on the impact of poor housing on poor health, there are relatively few (though a growing number) of 'intervention' studies demonstrating how better housing leads to better health.² Attribution is the biggest methodological challenge because (unlike a heart operation) the pathways to better health are complex and positive health outcomes may be influenced by confounding factors.

Nevertheless, there is sufficient robust evidence from case studies elsewhere in the UK and beyond to make a connection between

housing and health. We do not have to reinvent the wheel. As night follows day, as lung cancer follows smoking, so all the evidence, drawn together, shows good housing contributes to better health.

Cost-benefit

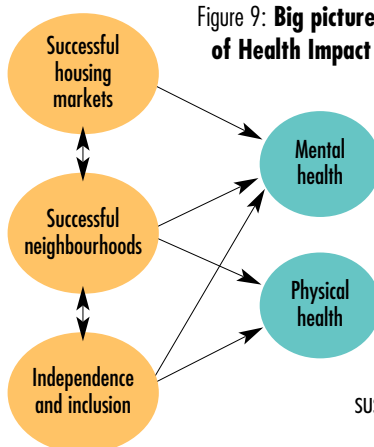
Cost-benefit analysis is demanding even when confined to the silo of a housing budget. (Will £X million capital investment add £Y million to revenue by reducing the number of letting voids?) It is even more challenging to estimate the health dividends from investment in the housing sector. (Will £X million capital investment on home safety prevent Y falls in the home and reduce NHS expense by £Z million and the Social Care budget by £2Z million?)

This HIA only sets the scene for such calculations. The *Housing Strategy* is a good starting point. It is comprehensive in scope and identifies strategies for achieving three key objectives by 2010. We have shown how meeting each housing objective can also deliver a health benefit and contribute to sustainable development.

Way forward?

The next step is about scale and focus; moving beyond the current family of supporting strategic documents, which are stronger on values, aspirations and policies. We recommend the commissioners of this report focus first on **three cost-benefit analyses** which will clarify the contribution of housing to health and relieve the pressure on health and social care budgets. **First**, we suggest a focus on potential health gains from improved energy efficiency and security in the private sector, especially the private rented sector. **Second**, we recommend the commissioners join with *Sheffield's Safer Community Partnership* to calculate the impact of housing on neighbourhood security and community health. **Third**, we recommend expanding *Sheffield's Joint Strategic Needs Assessment* to include a robust analysis of housing's contribution to reducing costs and adding quality of life to years of life lived.

Figure 9: **Big picture of Health Impact**



¹ Local Government Act (2000) HMSO.

² Hilary Thomson, Mark Petticrew, David Morrison (2001) Health effects of housing improvement; systematic review of intervention studies. *British Medical Journal*. Vol. 323: 187-190.