Health begins at home

Planning at the health–housing interface for older people

Lyn Harrison and Frances Heywood

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Tel no +44 (0)117 954 6800
Fax no +44 (0)117 973 7308
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Lyn Harrison is Senior Lecturer and **Frances Heywood** is Research Fellow at the School for Policy Studies, University of Bristol

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The problems: some examples

A single woman in her early sixties who has recently retired from work suffers a mental breakdown and enforced admission to hospital where she remains as an inpatient for four months. It is commonly assumed she is suffering from grief caused by the death of her sister, but in private conversation she says that her illness was mainly caused by anxiety about paying household bills on her reduced income.

A disabled but active and comfortably off woman of 70 approaches social services. She wants to know if she would be able to ask for help with cooking and domestic tasks if (as has recently occurred) she has a sudden serious bout of illness which prevents her from doing these things for herself and her 93-year-old mother, who is well but frail. (They went five days without food.) She also needs help to give her mother a bath. Social services say they do not provide housework-only services and that bathing can be arranged only if it is medically needed. The daughter becomes depressed, is unable to manage any longer and moves into sheltered accommodation while her mother goes into residential care, where she soon dies.

A man of 72 telephones the Housing Grants Department. He has just been told that his long-awaited grant will be delayed again and he fears that he will not live through the coming winter. The officer who calls on him sees, on the mantelpiece of his living room, boxes of pills prescribed by his GP, and inhalers for his asthma. The walls are bubbling with damp. When he opens the chimney breast cupboard, there is a waft of spores from the black mould that covers the inside. In his bedroom, as he stands gasping from the effort of getting upstairs, he shows how the walls are so wet that the paper he had put on has peeled off. The environmental health officer's heart sinks, as renovation grants budgets have yet again been cut.

Housing managers in a northern town meet to discuss their growing problem of void properties. Despite housing need and homelessness, they have too many 'hard-to-let' properties, including some newly built one-bedroom housing for older people on the outskirts of the town. This is causing revenue loss and capital outlay to prevent or repair vandalism between lettings.

All these examples are real, and are taken mainly from the authors' recent research work.

Preface

Housing issues are of fundamental importance to the health and independence of older people in Britain, but this is not reflected in planning for health, housing or community care. Primary care workers are uniquely placed to collect data on these issues but their potential is scarcely used

These three assumptions were the starting point of the research described in this report: that housing is an important contributor to the health of older people; that it is not routinely included in health or social care planning and that the potential contribution of primary care is wasted. The aim of the research was to test the assumptions and look for explanations and, where relevant, solutions.

For the link between housing and health we have relied on secondary sources and our own earlier work which had first led us to undertake this research. To check how extensively housing issues or links with primary care were included by those planning for public health and community care, a systematic analysis of community care plans and public health reports from three of England's eight health regions was undertaken. To understand the processes of planning, and the reasons why housing issues were not included in health and care planning, we interviewed practitioners and policy makers in three cities where housing/health links had been widely accepted. We also again drew extensively on the literature and the work of other researchers.

What follows in the report are our findings from these processes, and an analysis of what we consider to be the roots of this exclusion of housing issues.

Structural blockages as fundamental as the definitions of 'health' and 'housing', society's attitude to manual work; the hidden nature of older people's problems and the failure of planning to prioritise according to the level of need are identified and summarised in a chart (see Figure 2, p 20) which shows how they are interlinked and self-reinforcing.

The report concludes with one proposal of how things might work more effectively without requiring unrealistic changes and in a way that would complement other current initiatives. It offers a challenge to planners and joint commissioners to gather different kinds of information on need; to have long-term as well as short-term strategies; to think broadly across categories of issue; and to be prepared to invest money in new ways. Most significantly, by redefining the role of the Director of Public Health, it identifies a focal point where the responsibility and authority for coordinating, championing and review could lie.

There have been some major political and organisational changes since we began this research, and yet Primary Care Groups/ Trusts have been set up with no specified place for an appropriate housing professional and this suggests that the housing–health link is still not receiving the recognition it needs. On the other hand, with strong support from government for wider consultation and for preventative health interventions, the climate seems favourable for a consideration of these issues. We hope that this report will be a useful contribution to the debate.

1

Introduction: the challenge to planning

This report is not an exhortation to health, housing and social services authorities to work more collaboratively, nor is it proposing that GPs should attend more meetings. It is an explanation of why such exhortations have not been more effective in the past and contains proposals for other ways of tackling the issues.

Central to the report are two premises. One is that good housing (economical, sociable, secure, warm, well designed and located) and good housing services (housework, repairs, decorating, gardening, bathing, simple adaptations, better heating) together with transport that can transform a location, are vital to successful independent living for older people and the prevention of both mental and physical ill-health. The second premise is that investment in these twin factors will reduce more costly demands on health and social services and should be central to community care planning. With nearly 10 million people in Britain over retirement age, a third of them over 75, the promotion of preventative housing services is a sane policy, not a luxury.

We are conscious that there are some fine inspirational initiatives linking housing, health and community care underway around the country. People involved in these may be irritated by generalisations that seem to ignore their fine work, but we ask their forbearance. The report is concerned with the structural barriers that prevent such good practices from becoming the norm.

The report therefore offers an analysis, based on two years of research and dialogue with a wide range of people, of the structural reasons why the provision of good housing services has been so largely ignored by those who have had the responsibility for planning care in the community. It also suggests reasons why 25 years of joint planning and five years of joint commissioning have made no significant impact on these crucial housing issues. It subsequently proposes a structure to make use of the knowledge that exists among primary care and other front-line workers, as well as with older people themselves, of how housing-related problems affect health. This would provide the means to gather up such knowledge in a way that would be sufficiently powerful to influence planning. The objective would be to pump some of the resource in the great artery of health services into the starved extremity of housing services in a way which would be beneficial to all parties. If investment in better housing and in preventative housing services can reduce the number of expensive hospital admissions or increase the chance of successful discharge, and can offer a real chance of improving the quality of life of a quarter of our population, it is worth

considering why it has not been happening, and how it might be achieved.

The work has been carried out in an era when government has been encouraging all kinds of joint working designed to improve services and increase independence. We hope it will be seen as timely and as matching well with many current initiatives.

Structure of the report

The report looks (Chapter 2) at the historical and policy context to explain the current divisions of responsibilities for the provision of services relating to health, housing and community care.

The power of these and other key words and terms, and their definitions, are examined in a section crucial to what follows (Chapter 3).

Chapter 4 describes the research on which our thinking is based. Chapter 5 seeks to identify the problems and blockages that prevent the free flow of information on housing needs that affect health, and so prevent appropriate planning and budget allocation.

Chapters 6 and 7 present a possible vision for the future, with proposals for structural changes that could bring planning for housing and housing services into the heart of planning for good health and community care.

Case study examples given at the beginning and end of the report illustrate first the problems and then kinds of changes that could be achieved.

2

Historical and policy context

This work has taken place in the context of a Britain moving into the 21st century in a state of confusion as to the nature of British society and the divisions between public and private responsibilities. We are pulled in one direction by the overwhelming authority of capitalism and the global economy, which demands low taxation; in another by the tradition and force of social democracy in Europe (and, to a lesser extent through the United Nations and other world-wide institutions). This requires that we do not abandon the concept of a mutually responsible society which was established at such great cost in the first half of the century.

Continuities: the strength of the basic structures of health and welfare 1945–99

Between 1945 and 1951, the post-war Labour government established a National Health Service (NHS) within a wider welfare state. Fifty years on, life in Britain has been transformed. The Empire no longer exists, and the manufacturing base has all but vanished; we are a multiracial nation within the European Community and part of a global economy. We have witnessed staggering technological changes and scientific discoveries. Patterns of family life, the landscape, the measurements and coinage we use, even the food we eat have changed almost beyond recognition, and yet the basic structures of these two institutions have survived crises, rhetoric, reorganisations and reforms to demonstrate some remarkable continuities in the following ways.

Philosophy/ideology

The principles of the welfare state and the NHS were respectively a safety net of care for every citizen 'from the cradle to the grave' and a health service universally available and free at the point of use. In a free market economy there should be no room for either of these ideas and yet, even if strained to the limits and frayed at the seams, they are still in place.

Institutional structures

The Health Service was set up with a tripartite structure of hospitals, community health services and GPs. Patients had open access to a GP of their own choosing, who acted as a gateway to other health services. Central government organised payments to individuals, and local government other welfare services. All these structures remain in place, as do the cultural and educational divisions between 'health', 'care' and 'housing'.

Sources of funding

Despite the determined efforts of governments to find or promote alternatives, the sources of funding for health and social care continue overwhelmingly to be taxation and national insurance, with some contributions from patients or service users under charging policies and through charitable giving.

Levels of funding

The need to contain public spending, has been a consistent theme for five decades, but the levels of spending on health and welfare as a proportion of GDP have not varied much. Even during the period 1979-87, with a government committed to 'pushing back the boundaries of the state', public spending remained around 40% of GDP, and health service expenditure increased slightly to 5.75% of GDP (Webster, 1998). The major change has been a shift from public service provision to payment of benefits, particularly to those out of work. Within public service provision, the dramatic cut has been in public expenditure on the capital costs of housing, although indirect spending, through housing benefit, has gone up as direct spending has gone down (see below, under 'Housing').

Medical model of health provision and traditional professional roles

The NHS was set up to treat or to prevent ill-health mainly through the use of medical techniques. Although it has benefited millions of citizens, the medical model, which persists, has had some less desirable consequences. The lion's share of resources are still trapped by the acute sector, untouched by central government exhortations to shift them towards the prevention of ill-health or the long-term care of chronically ill frail people. Even nursing has been affected by a model which does not value or focus resources on such skills of nursing as coaxing a patient to eat, listening to concerns and offering reassurance, because they are not 'technical'. More recently, the changing structure of primary healthcare and the use of business management techniques and influence in the Health Service have begun to shift the balance a little, but the dominance of the hospital consultant has not entirely disappeared.

Medical practitioners retain their hegemony because of their highly specialised skill levels and power to save life in an immediate and visible way, reflected and reinforced by the nature of media coverage. The less dramatic work of other health, welfare and housing professionals continues to take second place.

Position of patients and service users

From at least the 1970s there has been criticism from both Left and Right of the lack of consultation and the non-responsiveness of public services to consumer views. There have been some changes in 50 years, most noticeably in the field of housing. Resident involvement began with planning, spread to urban renewal and has become widespread in the social rented sector, with some real impact. In the social and health services, there has been less effective change. People are informed of their rights and permitted to make complaints, but are not often proactively and pre-emptively involved in planning and management on a significant scale. Moreover, recent research into Health Service complaints processes suggest that they produce almost no outcomes that satisfy the complainants (Wallace and Mulcahy,1999).

Care in the community

While it was (and always has been) the case for the vast majority of older people live in their own homes, the authors of the welfare state were determined to help those in institutions; above all, to close the workhouses and move as many people as possible into 'homely settings' in the community. There are mixed motives for promoting this policy, and there have been periods of inertia in its implementation, but the objective of better care for vulnerable people, with dignity, in homes of their own, has endured.

Changes since the National Health Service Act of 1946

Public health severed from local authorities

One notable change since the NHS was first set up was the removal of public health responsibilities and community health services from local authorities to the NHS in 1974, while environmental health officers were left in local authority service. In the 1990s, Directors of Public Health became centrally involved in the commissioning role of district health authorities. Although they still produce annual reports they are in a weaker position to influence wider local policies which affect the health of their populations.

New models of disability

Another change was the growth from about 1980 onwards of the disability movement in Britain, and the evolution of the social model of disability. Although these developments have not yet made a major impact on services for older people, their long-term influence is likely to be significant.

Quasi-markets and the Health Service in general

The 1990 NHS and Community Care (NHSCC) Act introduced a market approach. The purchaser–provider split was devised to counter problems of inefficiency, complacency and lack of accountability. However, efficiency gains produced by competition were offset to a large degree by loss of the economies of cooperation, including a significant growth in transaction costs. Consumers were unlikely to experience the promised increase in accountability as their views were represented (normally without consultation) only through proxies. This period was marked by an increase in numbers of patients treated but also by a growth in patient complaints, increasing shortages of nurses and difficulties in recruiting doctors to general practice.

Primary care and public health

In primary healthcare, GP fundholding was an important innovation, but the 1990s also saw in parallel the development of locality commissioning, often among non-fundholders.

In 1992, the *Health of the Nation* strategy was launched (DoH, 1992) as a product of the World Health Organisation (WHO) *Health for All* (WHO, 1985), and *Healthy Cities* (Ashton and Seymour, 1986) projects. WHO themes of equity, community participation and intersectoral collaboration were thus infiltrated into British health policy. The 'health alliances' of 1993 (DoH, 1993), were attempts to achieve health gains through partnerships in local areas, and in 1996 the Public Health Alliance

published *Towards a public health model of primary care* (Peckham et al, 1996).

Social services as gate-keepers

The 1990 NHSCC Act made 'community care' a household term. From 1993 the Act introduced 'community care plans', internal markets, assessment and care packages to social services departments and led to an increase in prioritisation and charging. It gave social services responsibility for reducing the numbers of people in residential care and a transferred extra budget, 'Special Transitional Grant'. In England, however, authorities were required to spend 85% of this budget in the private sector and so were prevented from using this resource to provide extra domiciliary services themselves (this rule did not apply in Wales). Community care planning (much of it concerned initially with the continuing closure of long-stay hospitals) strengthened links between health and social services authorities. But older people who required help 'only' with housework or meals found their services withdrawn as departments, because of resource constraints, concentrated support on people who would otherwise have required residential placements. The result is that although the average number of home help hours per recipient has increased, the number of recipients has declined since care in the community was introduced.

Housing

Housing was the public service that suffered the most drastic reduction in direct funding during the years of Conservative government. From £12 billion a year in 1980-81, public capital expenditure on housing went down to £3.9 billion in 1996-97, despite the funding resource created by the sale of over two million council homes in Britain to their tenants. (In the same period, annual spending on law and order rose from £8.7 to £15.9 billion.) Similarly, Housing Corporation funding for housing associations, which was £2.5 billion in 1992-93 was reduced to £0.5 billion by 1996-97, as associations were encouraged to raise more of their finance from private lenders. Councils were not allowed to build new stock and were permitted to use only very limited amounts of their capital receipts to improve the stock that remained. Only the cost of housing benefit soared; rising from £5.4 billion in 1986-87 to £14.7 billion in 1996-97. In particular, the cost of benefit (rent allowances) paid to meet the charges of private sector and housing association landlords in England went up sevenfold in real terms between 1983 and 1994, rising from £483 million to £3,448 million at 1992 prices (Newton, 1994, p 96). These costs, however, are borne by the Department of Social Security (and, for council housing, partly by other tenants;) not by the Department of the Environment, Transport and the Regions, which is the department responsible for housing.

With much of the best stock sold, and allocation policies rigorously giving priority for what remained to applicants in greatest need, council housing became an increasingly residualised tenure. This has left many older tenants isolated and afraid to go out on estates where there are few middle-aged, employed people to provide stability and support, and a disproportionate number of unemployed, younger people and children. Owner-occupation grew, partly through the sale of two million council homes in Great Britain under the 'Right to Buy', but there was concomitant growth in homelessness, linked to repossession and negative equity. Council stocks have also been reduced through 'large-scale voluntary transfers' to housing associations, the favoured

providers of what is now termed 'social housing'.

In 1990, through the 1989 Local Government and Housing Act, measures were introduced which were of considerable help to older householders. These included a mandatory renovation grant, mandatory disabled facilities grant (DFG), Minor Works Assistance (now Home Repairs Assistance) and support for home improvement agencies. Since 1996, however, only the DFG remains mandatory and the reductions in housing budgets combined with increased demand has meant that many who need the other grants cannot obtain them. There is a growing number of older owner-occupiers living in housing they cannot afford to repair.

Policy developments since 1997

Following Labour's return to power in 1997, a cascade of policies relating to health and welfare have been issued. These include the White Paper of December 1997 *The new NHS*: *Modern, dependable* (DoH, 1997b), which heralded the abolition of the internal market in health; the introduction of primary care groups; a commission for health improvement; a duty of partnership between health and local authorities; Health Action Zones (HAZs); Health Improvement Programmes (HImPs); and a general emphasis on joint working. In 1998, the Green Paper, *Our healthier nation* (DoH, 1998c), linked poor health to social/ environmental issues, including housing, and proposed a strategic approach to improved health for older people through neighbourhood initiatives, including gardening services.

In June 1998 the government launched the Better Government for Older People programme, a range of local initiatives to encourage new partnerships to improve services for older people by better meeting their needs, listening to their views and encouraging and valuing their contribution, so they can fully participate in their communities.

Concern for these and broader issues of housing and support have also led The Housing Corporation, through its Innovation and Good Practice programme introduced in 1996, to fund over 70 projects relating specifically to housing and older people.

These and other relevant policy initiatives are summarised in Figure 8, p .

Conclusion

'An immovable object and an irresistible force': it is in this context of underlying structures and attitudes which have proved very enduring and the current government-led determination to introduce change and to make intelligent links between policy, disciplines and departments at national and local levels that the proposals in this report are made.

3

Definition of key terms

Housing and health are two of the most fundamental aspects of personal well-being. However there has been a reluctance on the part of the government to accept that housing conditions are associated with poor health. Government philosophy now individualises health issues; blame for bad health is often unfairly laid upon the behaviour of the individual rather than social and economic factors and employment circumstances which influence life style and living conditions. And because causal relationships between poor health and housing are difficult to prove conclusively, governments can easily ignore the association between the two, and thus avoid taking remedial action. (Leather et al, 1994)

In the rest of this chapter, bold type indicates our preferred definitions. Where no satisfactory existing definition could be found, we have composed our own; otherwise the sources are given.

Health

Health is a state of complete physical, mental and social well being. (WHO, 1958, Annex 1)

Health is a resource for everyday life, not the objective of living.

Health is a problematic concept to define and measure. We are adopting in this study a very broad view of health, which draws closely on the model developed by the World Health Organisation (WHO).

The dominant model of health in our society, which informs the formal institutions, professions and allocation of public resources associated with healthcare, is medical. This defines health as an absence of disease and is concerned with the treatment of disease through interventions in individual bodies, cells and even genetic material. The consequence of this is that doctors are accepted as the experts in health and health is normally measured by mortality and morbidity rates. The resources directed to health are mainly concerned with the treatment and cure of acute conditions within a hospital setting. The promotion of health and the care of people who have chronic conditions which are not amenable to cure, are given a lower priority.

Within this dominant model, the causes of ill-health are located within individual bodies and explained increasingly (particularly with the decline of infectious diseases over the past 40 years), by

individual life-styles or genetic make-up. This approach does not make strong connections between social, economic or environmental factors (such as housing) and the health of the population.

Primary healthcare

Primary healthcare is the service provided by general practice staff and the community health workers linked to practices.

Primary healthcare staff provide a continuum of services which include the direct treatment of individuals and referrals onto secondary (hospital) services. Equally important are the preventive and monitoring services aimed at the health needs of the majority of the local population, and the promotion of health within the population. This range of Internationally, primary healthcare forms an integral part both of a country's health system and of the overall social and economic development of the community and there may be lessons for Britain in this.

While there has been a huge emphasis on both the role of GPs and primary healthcare in taking the lead within the NHS there remains a lack of clarity about what is meant by primary healthcare (Peckham et al, 1996; Heath, 1997). The term primary care and general practice are often used synonymously. There are, however, strong arguments, which we support, for being clear that general practice is an essential component of primary healthcare but that, in eliding these two areas, both are damaged.

If primary care is equated only with general practice then primary care becomes driven by the medical model and medical practices. This inevitably shifts attention to dealing with disease processes within individual patients. However, primary care, as defined by the WHO, involves communities actively participating in all aspects of health promotion locally, and is concerned with the socioeconomic and environmental determinants of health.

Primary healthcare therefore needs to retain and value both the contribution of general practice and the broader components which can be offered by other practitioners, both within and outside healthcare. General practice itself should not be expected to take on a community-based public health function, nor adopt a socioecological approach to health. It should be enabled to carry out effectively its vital role of managing illness and treating disease through ongoing contacts with patients.

Other professionals should take on the local public health functions, and work with other agencies and communities to promote health and tackle inequalities. We would therefore see other professionals working in other agencies, such as occupational therapists and environmental health officers, as key members of the Primary Healthcare Team responsible for dealing with housing-related issues. It would be important, however, that this wider team adopts a social model of health and disability.

We are concerned that in the drive to make all public policies healthy, further areas of life are not medicalised, but equally that in ensuring primary healthcare embraces an holistic approach to health that we do not undervalue and dilute the specific contribution general practice makes in addressing the needs of sick individuals.

Public health

Public health is the science and art of preventing disease, prolonging life and promoting health through organised

efforts of society. (DHSS, 1988, based on WHO, 1952)

Public health medicine has traditionally focused on disease control within populations. This traditional approach was directed towards improving the health status of the population through the control of infectious diseases. These diseases were recognised as linked to inadequate housing and food, and lack of clean water and sanitation. Historically, then, public health doctors were involved with tackling poverty, which was understood as contributing to the huge regional and class inequalities in rates of death and illness.

In the 1990s a 'new public health' has emerged with a strong commitment to health promotion and to addressing the social and environmental factors which are seen as critical in determining the health of individuals and populations. Collaboration with other agencies outside the health field and community participation are key dimensions in the new public health programmes.

At the same time much of the work of public health doctors has been involved with their function in supporting the purchasing role of local health authorities. This has drawn Directors of Public Health and their teams towards issues concerning the clinical effectiveness of acute care, since this is where the vast majority of the healthcare resources are spent. This use of public health doctors to advise on clinical effectiveness has diluted the resources available to perform the public health function.

Housing

Housing is a physical structure within which a self-selected household lives, or a collection of such structures and is the hub of many human activities. It also means the provision, management or maintenance of such structures and their surrounding environment.

The physical structure is a place in which the basic human activities of sleeping, eating, washing, storage of possessions, social contact, recreation and care within the self-selected household take place. The word may also incorporate the attributes of the structure: its location, size, design, condition, accessibility, affordability, warmth and comfort.

For housing professionals it is the present participle of a verb and refers to the activity of planning, designing, financing, building and managing the structures, or the absence of them. For householders 'housing' implies the daily responsibilities of paying for, maintaining and managing the property, deciding who lives there and accepting the duties of paying, not just for the structure but for such consequent items as water, gas, electricity or council tax.

For many people, their housing also symbolises their own identity and life story: a place of retreat and privacy and also of display and expression of personal, religious, political and aesthetic values, as well as of achievement and status or wealth. Finally, housing as 'real estate' may be a form of wealth: seen as an investment on which a return may be received either as rent or increased capital value; as security against a loan, or as a valuable item to be bequeathed.

Housing is therefore a complex word, having physical, social, financial, symbolic and emotional meanings as well as referring to a great range of activities. Any of these may have implications for the physical or mental health and well-being of the population.

Planning

Planning is the process of looking ahead, choosing objectives and a course of action and being prepared for eventualities. It involves having a vision for the future and working towards it and its function may be either simply to be ready to deal with what arises or to prevent or alter it in some way.

In the field of public administration in democratic societies, planning will normally be carried out by groups rather than by individuals and be closely linked to the allocation of public money.

For the purposes of this research, planning in the fields of health, housing and community care will be taken to mean the process of determining objectives; deciding on ways to achieve those objectives, setting up structures and allocating resources accordingly. The process will often be preceded by the gathering of information and followed by a measuring of outcomes.

In theory, the planning process is a rational exercise of decision making based on an objective assessment of facts, probabilities and options. In practice, it is as much subject to the rough and tumble of political and economic influences, unenlightened self-interest, bad information, lethargy and lack of imagination as any other human activity. We are not unaware of these elements, but we are looking for the potential, and for the best examples rather than the worst.

When we talk about planning in relation to the housing dimension of community care we include the formal machinery of joint planning (Joint Consultative Committees, Joint Care Planning Teams and the allocation of Joint Finance), and the 'new' breeds of joint purchasing and commissioning. We also include the reviews and planning which may be led by health or social services or the joint planning machinery associated often with the main 'client groups' for community care.

Overall we are interested in the ways in which the mainstream budgets of health, housing and social services can be influenced, since relatively small percentage shifts in allocations can generate significant resources for new services or the expansion of existing ones.

Community care

Community care is a policy of supporting adults who need care *or* help of any sort – practical, personal or nursing – to live in their own homes and receive the *services* they need there rather than in hospital or residential institutions.

There are difficulties in using the term because it has come to mean different things to different groups.

The term originated within the health professions where 'community', used as an adjective applied to a range of services, means 'not in hospital'. 'Community care' related directly to the closing down of workhouses and long-stay hospitals for older people and people with learning difficulties or mental health problems, and providing a mixture of smaller residential homes and support services directly to people in their own homes. It meant professional care delivered in the community, and this is the definition that most non-professionals probably prefer.

However, over time, confusion has crept in and enabled government, professionals and academics to foster a second definition, which implied that community care meant care 'by the community', that is, 'not by

professionals'. The first task of publicly funded services "is to support and where possible strengthen these networks of carers" (Griffiths, 1988).

A third meaning of 'community care' currently in use is the legal one understood by social services professionals and used as a portmanteau word for services to the tightly defined groups to whom they have specific legal obligations as outlined in the 1990 NHS and Community Care Act, Section 46(3).

The major problem in using the term 'community care' in England in the early 21st century is the gap between narrow professional definitions, employed by those who, in order to ration resources, are pushed towards redefinitions – and the broader definition in common use meaning a general policy of support to all adults living in their own homes who need help, care or support.

The links between health and housing

It is, as we have seen, difficult to define concisely the meaning of health and of housing once we move away from narrow technical or professional approaches. This makes it difficult to proceed to consider the links between them but the subject is too important to be abandoned because it is difficult.

The work of Burridge and Ormandy (1993) brought together a wide span of modern research into the effects of housing on health, as well as spelling out clearly the problems of undertaking such research and a range of different methodologies, critically assessed. Ambrose too (1996) draws the conclusion from his review of the literature of health and housing that the relationship is problematic to specify and

> … the complexity of the relationships is bewildering when the 'holistic' nature of everyday life is recognised … the housing variable may sometimes be a determining factor and sometimes a contingent one – sometimes more a 'cause' and sometimes more an 'effect'. In short it is futile to look for a simple cause/effect relationship or to seek 'health gain' as an outcome of housing improvement alone. (Ambrose, 1996, pp 12-13)

Summing up, he says:

> … although many people living in unhealthy housing are also suffering from other problems, such as unemployment or crime victimisation, there is already overwhelming evidence from recent research that housing quality per se has a significant impact on health – something which has been realised by policy makers since at least the 1840s. Poor housing has been shown to contribute towards a range of physical conditions .... Housing also impacts on people's mental health because poor quality and overcrowded accommodation is associated with a range of problems including stress, anxiety, depression and insomnia. (Universities of Sussex and Westminster, 1996, p 16)

During the research, we tried to look even further, and to bear in mind the effects on mental health of issues beyond house condition, such as housing design, social stratification, allocation policies and lack of housing services.

4

Research methods and findings

This study was influenced by the researchers' own previous or ongoing research and a national survey of annual reports and plans. In addition, empirical data were generated from field visits, interviews and local documentation and searches of published literatures.

In this report we comment on the findings from the survey and the field visits.

The national survey

To discover how widely the impact of housing issues on health and effective community care featured nationally in planning for services to older people, we scrutinised community care plans and reports of Directors of Public Health. All the plans or reports covering the year 1996-97 that we could obtain from three of England's eight health regions – North West, South West and North Thames – were systematically read. At the same time we searched for any references to primary care and for instances when primary care and housing issues were linked.

A total of 37 community care plans and 39 reports of Directors of Public Health out of a potential 49 and 42, respectively, were read in this way and the findings were as follows.

Key points from community care plans

Housing issues marginal in most plans

Homelessness was the housing issue most commonly mentioned in community care plans. Older people do sometimes lose their home, but numbers are very small, rehousing is usually swift, and it was clear that this was not the aspect of homelessness with which the community care plans were concerned. Homelessness has therefore not been included as a housing issue relevant to older people in the analysis of the plans.

Figure 1 shows the percentage of community care plans in which housing issues affecting older people were mentioned either directly or through implication in a proposed course of action. The references to housework were often mentioned only in the section of the plan where user views were recorded.

No sense of scale of proportion

Where housing was described as essential to community care (16 out of the 37 plans) this referred mainly to 'special needs' housing, not the needs of the majority client group. Plans did not normally contain statistics which showed how many older people there were, where they lived, the

housing needs they had or the scale of remedy needed. One exception, the Hertfordshire Plan, recorded that there were 13,000 people over the age of 85 in the county, 10,300 of them in their own homes, of whom 6,100 lived alone. This powerfully illustrates what was missing in most other plans.

Contacts with primary healthcare

Mentions were minimal. The advent of Primary Care Groups/Trusts is likely to make a major change in this respect.

Joint Finance for housing

Only one third of all the plans showed any Joint Finance input into housing. Projects supported included Home Improvement Agencies (HIAs), a bathing project and schemes for home and garden maintenance. These demonstrate the need and the potential, but they are rare.

Figure 1: Housing issues affecting older people mentioned in community care plans for 1996–98

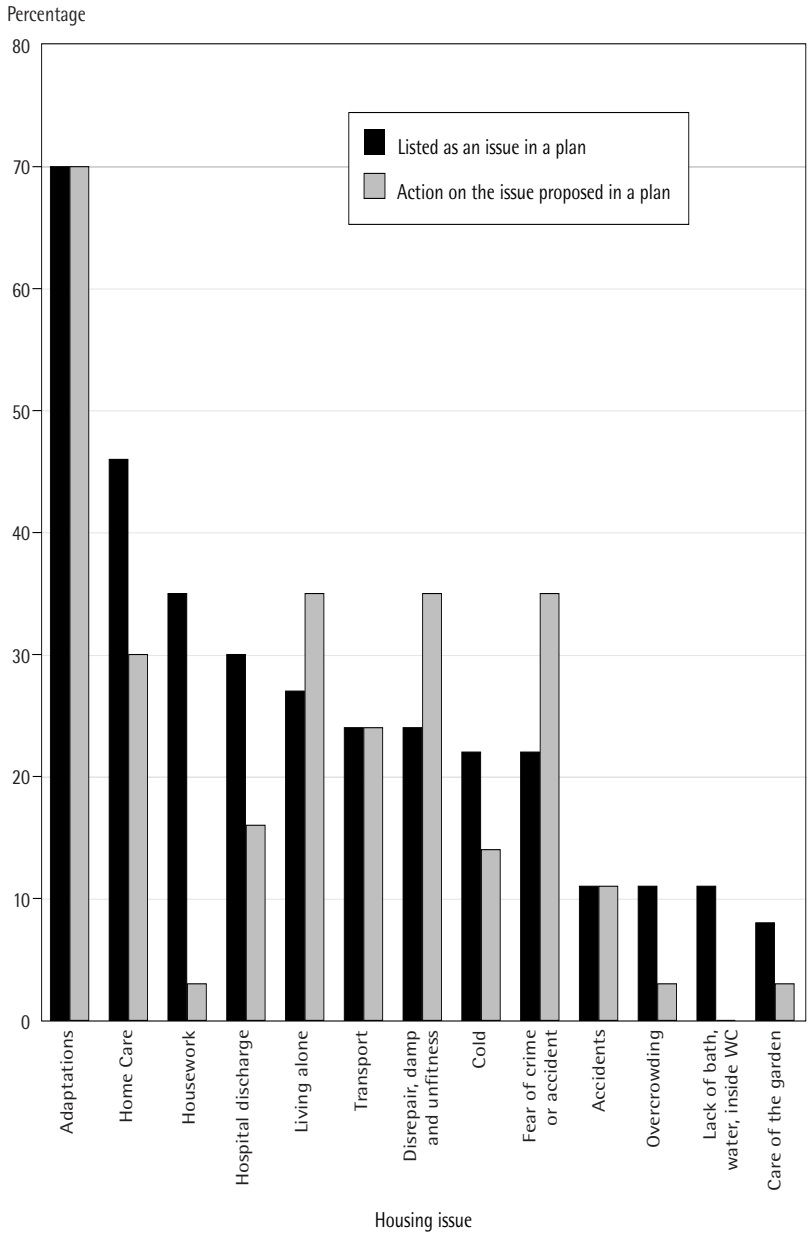


Table 1: Projects linking housing, health and community care found in 37 community care plans* for 1996-97 (on planning to implementation continuim)

Aspirations	Proposals	Actual mechanism for joint planning	Actual projects with tangible outcome for users
Gloucestershire In its section on services for older people, said there was need for "systematic approach to gathering information about a particular part of the population to better understand their need of health services, personal services, housing etc"	*Bath and North East Somerset* The joint housing and social services department had agreed with the health bodies to integrate assessments undertaken in hospital and discharge procedures	*Cornwall* Locality groups set up by health authority to plan priorities for improving health included housing officers and environmental health officers and were to work in parallel with the GP consortia set up in every district	*Somerset* Staff in social services, health and housing used a common referral form to alert one another to the community care needs of clients
Barnet Exploring idea of having joint officer teams comprising health, social services and housing	*Somerset* Locality commissioning fora for health proposed to include representatives from housing and social services and a lead GP	*Gloucestershire* Joint strategy groups for various client groups included health, housing and social services	*Bury Metro* Social services and housing had a social needs panel relating to mental health to ensure appropriate allocation and support
Barking and Dagenham Need to establish integrated housing, health and care services for a proposed new housing development for up to 15,000 people	*Wiltshire* Closer joint working between social services, housing and health and some joint training on mental health proposed	*Somerset* A housing representative from each district attended at least one user-specific planning team to feed into Joint Care Planning Team	*Rochdale* Used Mental Illness Specific Grant (MISG) to support a worker to help homeless people with a mental health problem
Essex Short-term policy objective to ensure collaboration between health, housing and social services on acute hospital discharge	*Liverpool* Joint training of social services, health and housing workers was proposed	*Wiltshire* Housing officers from West Wiltshire included in the new joint planning structure	*Bolton* Training by housing for front-line social services and health staff
Tower Hamlets Exploring idea of having joint officer teams comprising health, social services and housing	*Barking and Dagenham* Proposal made that all new public sector housing and 20% of private sector should be built to Lifetime Homes standards	*Liverpool* Director of Housing a member of the Joint Care Planning Team	*Bolton* Had completed pilot of home accident prevention checks to older patients of some GPs
St Helen's Metropolitan Borough Council "Joint planning arrangements should impact on the whole of the budgets controlled by the local authorities and health authorities, not just on the small amount encompassed by joint finance ... needs to be recognition that improvement of health is strongly influenced by housing...."	*Barking and Dagenham* Programme to install central heating in 11,800 properties	*Liverpool* From 1993, new planning structure to coordinate multi-agency approach to health and community care issues. Establishment of Joint Public Health Team, including one task group on housing and health	*Barking and Dagenham* Council had established a housing and health department, Home from Hospital team and Care at Home service
	Havering Proposal for joint officer teams including social services, health and housing	*Liverpool* Each Joint Care Planning Team subgroup had housing representative *Camden* Included housing representatives in its Joint Commissioning Group *Hertfordshire* All agencies had taken part in a joint housing needs identification process in 1995	

* 20 of the plans had no mention of any projects meeting this description

Joint projects: housing, health and social services

Table 1 shows all the schemes that in any way linked housing and health and community care in these 37 plans. In 20 plans there was nothing of this kind at all. In the other 17, statements of intent exceeded concrete projects, but some plans, including those from Bolton, Cornwall, Gloucestershire, Liverpool and Wiltshire, listed excellent examples. Especially notable was Barking and Dagenham, with a newly established housing and health department and evidence of finance allocated to housing to achieve health gains. It should be added that community care plans are as much about describing the status quo and what has been achieved as about forward planning, so it is not unreasonable to look for evidence of schemes already underway in them.

This lack of concern with housing issues contrasts with repeated research evidence showing the services older people most value and need in order to retain independence.

Key points from reports of Directors of Public Health

Different approaches: common isolation

The Public Health reports fell into three main types, focusing respectively on clinical interventions, life-style health education or the socioeconomic causes of ill-health. A common thread, however, was a sense of the isolation of public health and the futility of so much skilled input into reports there is no power to implement, since there is no existing statutory obligation on statutory agencies to act on reports from Directors of Public Health. This was summed up by a Director who wrote in his report "An annual public health report can, to the people who write them, be similar to talking to yourself." (North and East Devon, 1996 p 1).

Links made between housing and health

Although half the reports, including some from areas with serious housing problems, made no mention of housing issues, in the other half, a total of 63 different housing issues impinging on health were listed. These housing issues are listed in Table 2.

Proposals for action

In Cornwall, health monies had been invested in an experiment to test health gains following improvements to heating in council stock.

An annual public health report can, to the people who write them, be similar to talking to yourself.

Information links with primary care

A majority of reports had positive statements supporting data exchange between primary care and health planners, and real examples were given for East Lancashire (stroke) the Isle of Wight (asthma) and Salford and Trafford (diabetes). Gloucestershire had an accident liaison health visitor.

Table 2: Housing problems listed as affecting health in annual reports* for 1996–97 of Directors of Public Health from three health authority regions: 39 reports srcutinized; in 18 cases no housing factors at all were mentioned

Physical condition (items relating to statutory fitness) Damp (7) Poor sanitation (4) Water supply (4) Dangerous structure (3) Lack of amenities (bath, hot water, WC) (3) Unfit (2) Substandard Disrepair Asbestos People living in shacks, huts or dilapidated caravans *27 mentions in this category*	**Costs of housing** Lack of affordable heat (5) Water metering Cheap, less safe household appliances High cost despite being substandard High rents and low wages Housing association rents too high Costs of electric fires and portable gas heaters Gas oven used for heating *12 mentions in this category*	**Design and safety** Poor lighting (6) Poor design (5) Noise (4) Slippery floors (4) Unadapted (4) Lack of smoke detectors (2) Stairs (2) Crime or fear of crime (2) Poor quality glass Inconspicuous steps and sills Dangerous heating appliances Houses in Multiple Occupation Hazards in the home, including loose wires, non-expanding kettle flexes, unsafe storage of chemicals, garden tools etc, no stairgate, no fireguard, no window locks and unguarded electrical sockets *41 mentions in this category*
Neighbourhood or location Lack of transport (5) Polluted air (5) No social cohesion (2) Poor estate design (2) Heavy traffic in the street (2) Vandalism Traffic pollution Polluted land "No school, no corner shop, no church, no playground, no bus." *20 mentions in this category*	**Control, independence and security of tenure** People wanting to live in their own homes No choice about where to live Having to move in old age *3 mentions in this category*	**Ability to manage or need for support** Older people living alone (5) Unsuitable housing Good housing for older people Need for support in daily life when mentally ill Lack of help with housework *9 mentions in this category*
Absolute shortage of housing Homelessness (10) Flat, not house (2) No building of new council houses (2) *14 mentions in this category*	**Comfort and amenities** Cold (9) Not having own phone *10 mentions in this category*	**Size and space, relative to the occupants** Overcrowding (7) Living with relatives *8 mentions in this category*

Note: numbers in brackets indicate number of reports in which issue was mentioned, if more than one.

Conclusion

The potential of Directors of Public Health to contribute to community care planning is wasted. Many of them see the links between housing and health and would be well placed to commission information from Primary Care Groups and to use it to inform strategic planning that would include housing issues.

Field visits and interviews

The national review indicated that the housing/health needs of older people were not being fed into the processes for planning community care. A number of field visits were then carried out, selecting locations where there were features conducive to connections being made between an understanding of the housing needs of older people and the funding and

delivery of appropriate housing services. These included features such as *Healthy cities* initiatives, and long-standing urban renewal programmes.

In the field visits a range of individuals were interviewed, including front-line staff, planners, managers and researchers. The purpose of the interviews was to identify the factors which supported, and those which inhibited, the development of supportive housing services for older people, and how any required changes in policy and practice could be engineered.

The core questions asked on these visits were:

- How can information held by primary care workers on the housing needs of individual patients be aggregated and fed into planning processes?
- How can the views of individuals and communities about their housing needs influence housing decisions?
- What examples are you aware of locally where health money has been spent on housing issues?

Responses from practitioners

Interviews were held with environmental health officers and health visitors who had been involved in community development and participation projects as coordinators between health and social services or as board members of locality commissioning groups or in practical projects linking housing and health. Themes that emerged from the interviews included:

- Awareness of how cut-backs in housing grant funding had adversley affected older people's health.
- Difficulties of persuading GPs to take an interest in issues outside the strictly medical.
- Focus of both GPs and social services on problems with individual people/ families. Not trained to think strategically. Public health and housing both more attuned to strategic planning.
- Experience of satisfying community projects carried out between housing and health project officers.
- Frustration that projects linking housing and health were pioneered, found to be effective, and not made mainstream.
- Frustration at how the views of patients, especially women, were not heeded by the mainly male GPs when put forward by female non-GP health professionals.
- Frustration at the reluctance of senior managers in health or social services to heed grass roots information, even when they were funding projects to secure it, or to cooperate with each other (this finding is also in the literature).

Responses from policy makers

Interviews were held with policy makers and researchers concerned with local developments relating to the public health of communities. Common themes were:

- The problem and waste of short-term approaches and projects.
- The lack of priority given to preventive work.
- The need to be able to break down and 'trade' across budgets between health and housing both nationally and locally.
- The need for an area-based public health capacity.
- The separation of environmental health officers from public health departments.
- The reluctance of social services to accept their service users' experience of housing problems as legitimate issues to be addressed.

- The need for good quality local research to demonstrate the link between housing and health.
- The potential for disaggregating national data and applying it locally.
- The benefits of an ongoing community-based focus providing continuity.

The pictures conveyed, by both practitioners and policy makers, had many common elements which each described from their own professional perspective. We give here just three examples to illustrate the kind of evidence that was given in these interviews about structural blockages to a flow of information on housing needs into the planning processes of health and community care.

1. Blockages at the first level were described by the senior urban renewal manager in Birmingham who had fostered the 'SNUG' project. This scheme allowed GPs to 'prescribe' housing repairs (through a Home Improvement Agency) to patients whom they thought would otherwise need to be admitted to hospital or residential care. A great deal of painstaking work had to be put in to overcome the initial reluctance of the GPs to take part, although, once the programme was underway, some of the doctors became highly supportive.
2. A blockage at a different level was described by a liaison worker, who had been appointed to a Joint Finance funded post. She expressed frustration that, although she was required to gather information on community health needs (many relating to housing), there was no mechanism for feeding this information back to the senior managers in health and social services who were responsible for creating the posts.
3. Finally, the Liverpool Housing Action Trust provides an example of a potential problem at policy-making level where short-term costs have to be weighed against longer-term benefits. This HAT is made up of 60 tower blocks, which house a high proportion of older tenants and also a more-than-usual number of single younger men. Intensive input into housing issues, including home visits and consultation, together with new health service provision, led to increased contacts with GPs by these single men. Short term, this could be seen by policy makers as investment in housing leading to an increase in health service costs. What would be needed would be a view long term enough to see the value of earlier, more preventative interventions when measuring outcomes.

Conclusion

This scrutiny of planning and public health documents combined with interviews with professionals involved in projects linking health, housing and community care, have led us to conclude that:

- The key role of housing in community care and as promoting the health of older people is still not recognised in most areas.
- There are fundamental reasons why this is so, which are considered in the following chapter.

5

Problems and blockages

The data generated in this and other studies revealed that the planning systems currently operating were failing to deliver appropriate care and support for older people, in relation to the interface between health and housing. The next steps were to identify the blockages in the systems and realistic ways of tackling them. However, the blockages when examined were found to be practical manifestations of more intractable underlying problems, and it is these structural factors which make change so difficult to achieve.

Problems

The problems which were identified are deeply embedded within institutions and societal attitudes and not easily amenable to change in the short term. These are summarised below. There are exceptions to many of these generalised statements but we are concerned to describe 'what most commonly prevails'.

Concepts of health and housing

The words 'health' and 'housing' have come to have very narrow and specific meanings in policy and practice. Health in this definition refers to the absence of illness. Services which relate to health are provided by the NHS and the experts in this field are doctors. The medical(ised) model of health and of disability is dominant over the social model in the planning of services which require joint working. Housing in this definition refers to bricks and mortar which provide physical shelter. Housing services are concerned with the allocation and maintenance of housing stock, and the collection of rent in the public sector. The words therefore invoke automatically the attention and involvement of certain agencies, professionals and budgets, and exclude or ignore others, in particular, environmental health officers.

The impact of housing on health

There is a view that, since we have got rid of the vast majority of unfit houses, we no longer have health problems relating to the housing of the population. The impact of housing on the health of elderly people needs to be understood in relation to the circumstances of the 1990s. The issue is not championed and represented within the planning processes locally. There is no systematic collection of data relating to the housing circumstances of older people and its impact on their capacity to get the most out of life. The knowledge of front-line staff and of older people themselves is not acknowledged or used. The budgets which could provide housing services, such as Joint Finance, are not used for this purpose,

or are not used creatively to ensure the provision of appropriate services.

The role of public health

Many public health doctors nationally have shifted their focus of work away from public health and towards public health medicine.

Public health doctors have taken on a major role in advising local health authorities on their commissioning functions. Partly for this reason, and also because they do not have statutory authority to direct other agencies or professionals, they are not in a position effectively to champion the housing impact on health or coordinate the work of professionals in this field.

Public health doctors are not closely involved with planning processes locally and have not had close joint working relations with primary healthcare or community health staff.

Planning

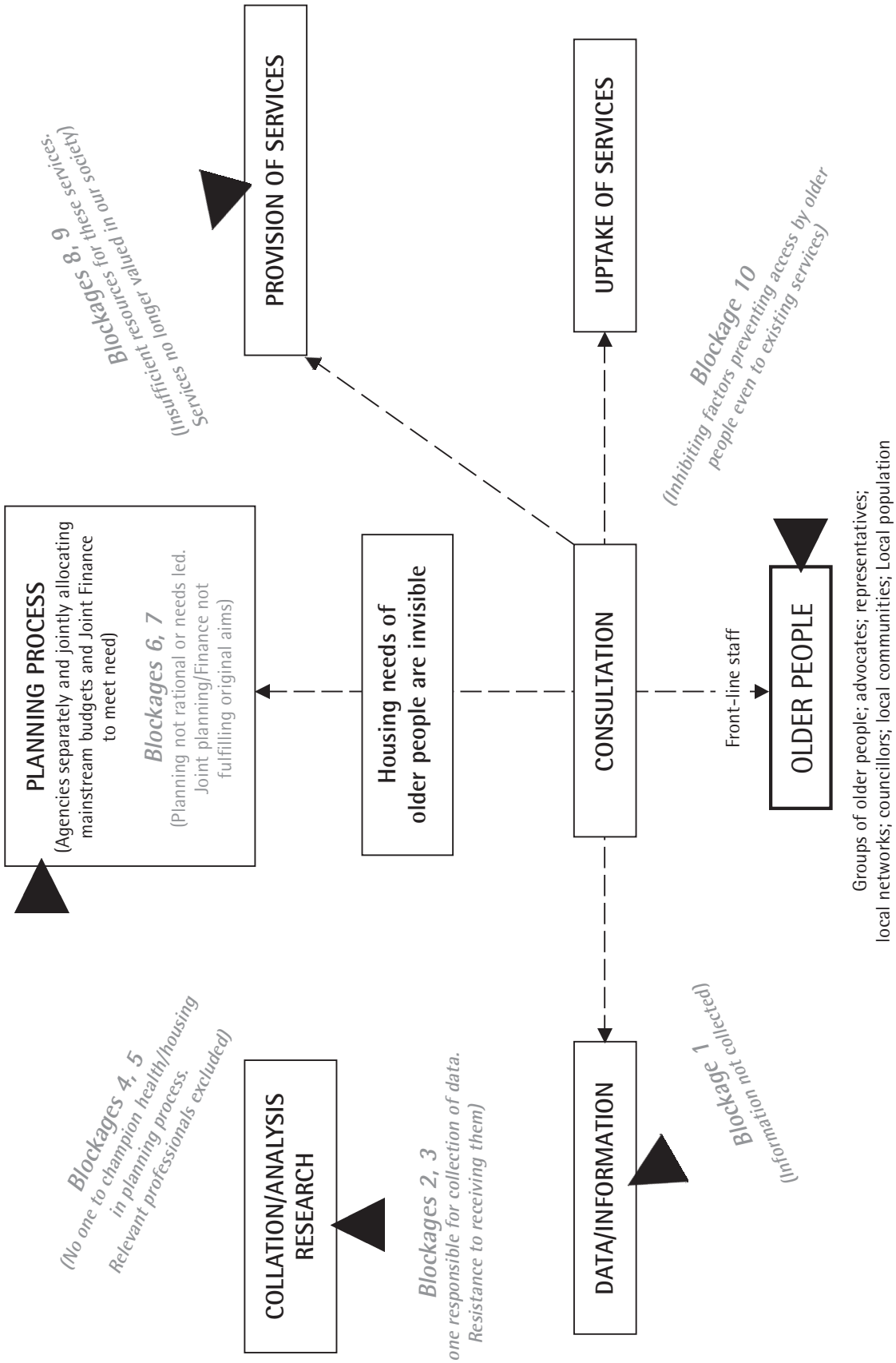
The normative view is that planning processes are rational and scientific. In practice they are subverted to 'political' priorities. Within planning processes there is a lack of sense of proportion, with the scale of the problem or the level of need not relating to the amount of attention or resources allocated. This tendency is powerfully illustrated by the allocation of budget in a policy statement made by the Deputy Prime Minister on 22 July 1998. A total of £2.7 million additional funding over three years was made available to Home Improvement Agencies who have a clientele of 20,000 people a year but a potential clientele of several million older people if resources were not so constrained. In the same statement, an extra £38 million over three years (to a total budget for three years of £145 million for London alone) was allocated to tackle the problems of an estimated 1,000-2,000 rough sleepers. This comparison is made, not to denigrate the much needed provision for rough-sleepers (and the initiative is likely to benefit others in great housing need, not just the 2,000), but to put in perspective the amount made available for a less visible client group.

There is limited democratic control, accountability or scrutiny in relation to priority setting and allocation of budgets locally. Organisational and professional barriers prevent most forms of joint planning being effective both at the national level (across government departments), and at local levels (between health authorities and local government).

The nature of the need and the services needed

Older people in our society tend to have low status. The 'hands-on' housing services needed by frailer older people in their homes are also low status. Housing support in the domestic setting is not a priority since it is 'invisible'. This relates to it being part of the private domain of people's homes, and to the extent to which it no longer formally occupies most of the working lives, paid or unpaid, of women. The reduction in the provision of such support is also a result of domiciliary resources being used increasingly to provide personal care in the home, because of the shift of care out of hospital into the 'community'. No one is willing or interested in owning the need to provide such housing support for frail elderly people because it does not enhance professional or managerial status, or have sufficient clout to demand political attention.

Figure 2: Meeting the housing needs of older people living in their own homes: the blockages



Blockages

Figure 2 represents the series of blockages which prevent adequate and appropriate services being available to meet the housing needs of older people. These blockages are the practical outcomes of the problems described previously. They are the explanations offered by managers, planners and front-line staff as to why the housing and health interface is not adequately addressed: they are the barriers identified in research and evaluation on joint working in general, and community care in particular.

The diaspora of housing/health information (Blockage 1)

The information in the community on how housing issues affect the health of older people is not routinely sought, and even where it becomes evident, is widely scattered and is not collated (Burridge and Ormandy, 1993, p xxxii). This is despite the fact that there is a range of professionals who have contact with older people in their own homes or other opportunities to collect and analyse data on the health/housing interface for planning. In addition, the knowledge which older people themselves have on how their housing is affecting their well-being is not valued.

No one is responsible for commissioning, collating and publishing data on housing factors affecting health or community care (Blockage 2)

No front-line professional is required to collect data on the housing circumstances of older people they see. There is little local scientific research on the evidence of links between housing issues and good or bad health. No one has the duty or power to require front-line staff to collect data, to assemble research evidence, either national or local. No one is obliged to publish the findings every year and to answer for them.

The resistance to receiving this information (Blockage 3)

Planners may find it useful explicitly to remain ignorant about the levels of certain needs because it is impossible for the resources available to match such need. In addition, planners and managers at the interface between local and national levels tend to remain locked into particular models of care, and are cut off from the 'bottom-up' influences which might persuade them to re-think the model. Systems effectively suppress the process of voiced demand leading to supply. This tends to perpetuate traditional forms of service delivery and, in the case of community care, has isolated the role of housing and inhibited the provision of a range of housing services.

No one has the role or responsibility to champion housing issues in local planning processes (Blockage 4)

The professionals who might have the information to champion the housing/ health issues of older people are not generally part of the local planning processes (Blockage 5)

There has been virtually no involvement of GPs or other members of primary healthcare teams in local planning processes at the level where decisions about budgets are made. Neither are data from the primary healthcare fed into these processes. Similarly there is limited input from Public Health Departments in local planning. Housing staff and environmental

health officers have not played a critical role in joint planning for community care, where health and social services have been the dominant partners. Occupational therapists, who at the front line are the social services staff most likely to be working jointly with housing, have not had a significant impact on community care plans or joint planning.

Rational needs-led planning is evident only in rhetoric and is over-ridden by other priorities in practice (Blockage 6)

National priorities are very significant in driving the planning process at the local level. This filters out expressions of need from users and front-line staff which do not fit with these priorities. The dominant model of disability is still a medicalised one, and user-led and needs-led approaches to assessment have not replaced the service-driven mode of delivery of health and social care.

There are a number of structural weaknesses in the way in which Joint Finance is allocated (Blockage 7)

The decisional level of joint planning has become the province of senior managers from the agencies involved. This tends to exclude wider interests and the knowledge of operational staff. The importance of the housing dimension of community care is not strongly presented within joint planning. Housing and environmental health officers are not automatically included in joint planning teams, and, since housing services are not a priority for health and social services, there may be no housing champion on the planning team. Since, in relation to health and disability, it is the professionals working in the NHS and social services who are accepted as experts, it is unrealistic to expect housing staff to challenge prevailing models, priorities and the pattern of resource allocation for services. Even if housing professionals make a proposal, colleagues from health and social services may feel it should be funded from housing budgets. Joint planning is tied into the allocation of resources in response to bids, rather than relating to the overall levels of need, and there is an emphasis on innovation. The outcome of all these factors may be that important housing services affecting a large number of older people may fail to attract joint finance resources.

In order for housing services to be delivered in the volume required, either new money must be found, or money shifted from within existing budgets (Blockage 8)

At present many older people are unable to obtain basic services, such as gardening, cleaning, furniture removal, safety checks on heating and lighting, minor repairs and adaptations. While some of the costs of these services may be met by older people themselves (since ability to pay is only one of the barriers), it is clear that public sector finances will be needed to ensure these services are delivered equitably to frail elderly people in their own homes.

There is a long established trend in society working against the provision of labour intensive 'hands-on' services (Blockage 9)

A number of recent policy priorities and trends in managerialism, along with the well established processes of occupational advancement, have resulted in an ethos which devalues housework services in the context of community care. The high priority placed on shorter stays in hospital

has resulted in community health and social services providing more personal and nursing care to dependant people in the community. Home help services have shifted away from their traditional role of domestic support.

There are factors which inhibit older people from learning about or gaining access to services which would help them overcome housing difficulties (Blockage 10)

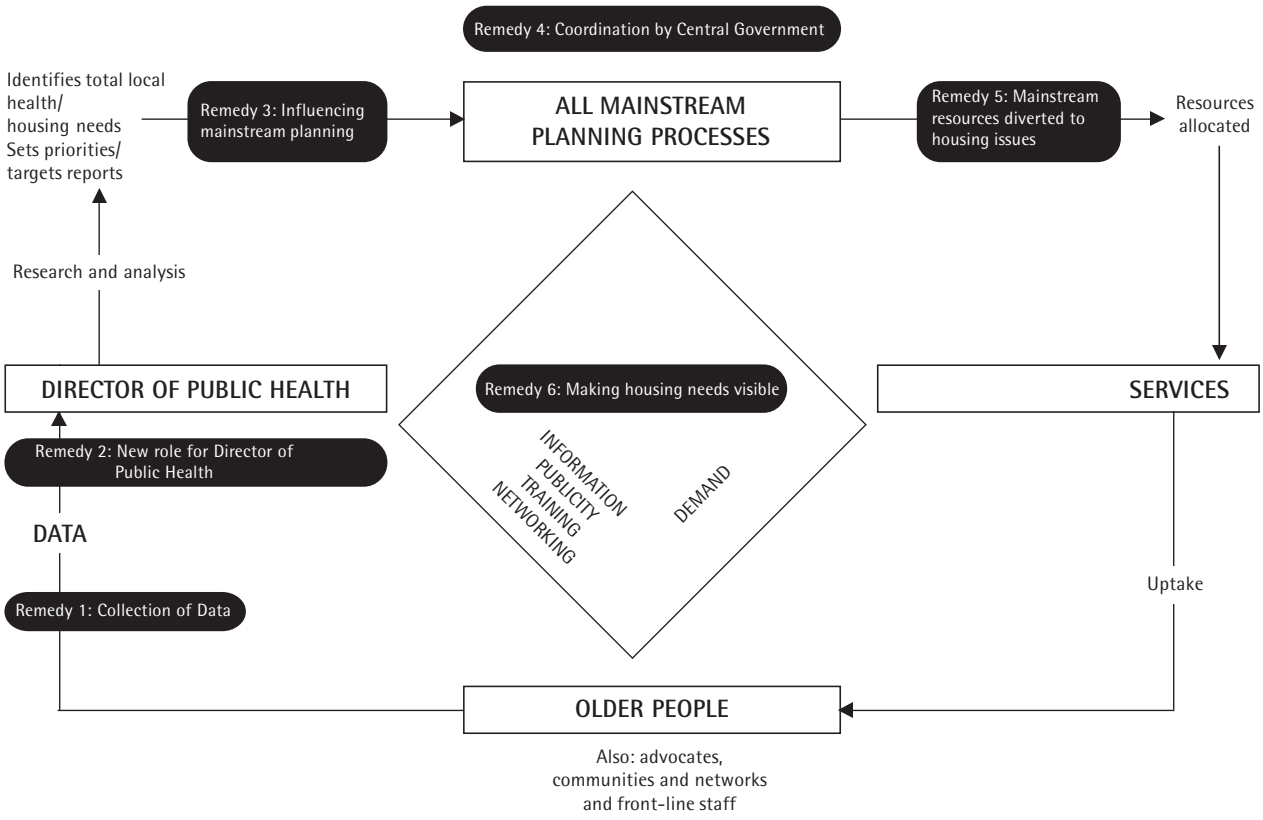
Information on housing rights and options is not often readily available to older people. Ignorance is fostered by some local authorities as the essential buffer between people's statutory rights and the council's inadequate resources. Non-housing professionals who work with older people are not usually well informed themselves about the range of possible housing solutions for older people which exist across all tenures. At another level older people's anxieties may prevent them from seeking help. Many fear the disruption or cost of building work, or being forced out of their own home.

6

Vision for the future

We conclude this report by drawing together the information and ideas we have gathered to create one possible option for the future, which would result in the health/housing needs of older people being met. This model we believe is feasible, given what is already happening in practice, and given the emerging policy environment. In the Conclusion (Chapter 8) we present an illustration of the impact this model could have on services. The remedies needed to achieve the vision and how they interrelate are represented in Figure 3. The individual remedies are then briefly described.

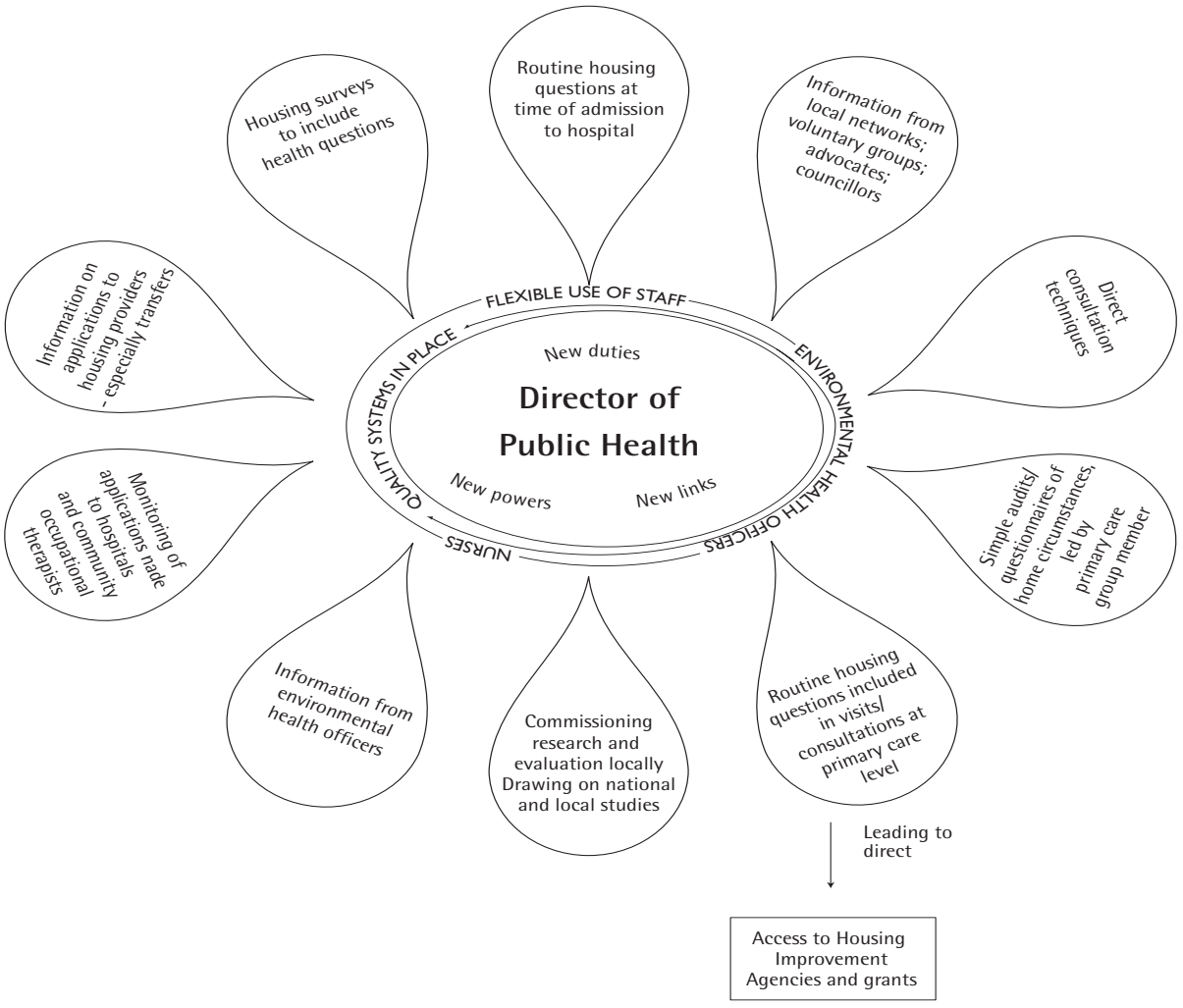
Figure 3: Proposed vision of how things could be



Remedy 1: the collection of data

Resources need to be directed to the collection and collation of information relating to the impact of housing on the health of older people. Simple trigger questions could establish whether older people have problems with cold, damp or managing the stairs; whether they need help with housework, bathing, gardening or decorating; whether they have problems with their neighbours or anxieties about the costs involved in running their home. Prototype questions have already been produced by several agencies, including Care and Repair England and the recent Housing Options for Older People methodology (short version) available through the Elderly Accommodation Counsel (Heywood et al, 1999). The figure below suggests a range of sources of these data for planning and how they could be collected. It is essential that the relationship between health and housing is seen as a priority and that data are systematically collected in order to understand the problems which are being experienced in the local context. A sustained infrastructure, which is agreed nationally, is needed with someone clearly accountable locally for this function and with monitoring the impact of data on planning, funding and ultimately on health outcomes.

Figure 4: The collection of data



Remedy 2: The new role for Directors of Public Health

In order for the 'housing' services needed by older people to be available, the level and nature of need has to be championed within planning processes concerned with the allocation of mainstream budgets for housing, health and social care.

We therefore are proposing that the government requires Directors of Public Health to produce annual sets of performance indicators and data which reflect the overall extent to which housing needs that are affecting the health of older people are being addressed locally.

This requirement is the most critical element of the entire vision and requires a considerable shift in the status, duties and accountability of Directors of Public Health. These are indicated below.

Figure 5: New role for Directors of Public Health

Directors of public health will:

- be accountable to the Chief Medical Officer or Minister for Public Health
- be more independent of their local health authority
- have an input to all local major planning fora
- innovate and dissemiinate new models of older age and disability
- work with Primary care Groups to provide the necessary public health skills
- work also with professionals outside the health service

The duties of Directors of Public Health will be:

- to produce annually for Central Government departments, sets of performance indicators and data
- to collect housing/health data and champion health/housing issues
- to report to and through a regional body

The powers of Directors of Public Health will be

- to require health authorities, NHS trusts, primary Care Groups, local authorities to collect data and demonstrate action taken in response to Director of Public health's reccommendations vis à-vis housing/health

Nature of the post

The post should be independent of the local health authority and Directors of Public Health should be accountable to the Chief Medical Officer or directly or indirectly to the Minister for Public Health. At the regional level the Director could report on the performance of health authorities and local authorities, in relation to health/housing provision, to the Audit Commission, the Planning Authority, the NHS Executive or the Social Services Inspectorate.

Powers

Clearly defined powers are needed to ensure that:

- Directors must approve local plans and policies which impact on the allocation of resources to housing services for older people, such as community care plans, Health Improvement Programmes and Joint Investment Plans as well as Housing Investment programmes.
- Directors can require local agencies to collect data and demonstrate how they have taken action in response to their recommendations vis-à-vis health and housing.

Duties

Directors of Public Health should have the following duties in relation to this aspect of their work. The list we give here relates to older people as that has been the focus of this report, but if the principle was felt to be good, the responsibilities could extend to other vulnerable groups, including, for example, disabled children, adults with mental health problems, travellers and refugees.

- to specify, and coordinate the collection of, housing/health data relating to the population over retirement age and champion health/housing issues in general locally;
- to specify the housing problems and issues affecting the population over retirement age and set objectives in partnership with local agencies and communities;
- to have an input into all major planning fora which influence the allocation of all local mainstream budgets;
- to take a lead in relevant teaching and training locally so that new models of older age and disability are disseminated and understood;
- to take a lead in coordinating the range of professionals who can access relevant data and have direct knowledge of the needs of older people in relation to health/housing issues (such as community nurses, public health nurses, environmental health officers, occupational therapists);
- to take the lead in coordinating a range of consultation activities which involve older people, communities, organisations for and of older people, local councillors and other representatives;
- to provide annual progress reports on targets or indicators set nationally and/or locally to the Chief Medical Officer/Minister for Public Health.

Remedy 3: Influencing mainstream planning

We are proposing that the allocation of local mainstream budgets should be responsive to the overall need for housing services of the retired population, and that this could be achieved through inputs of the Director of Public Health into planning

Remedy 4: The role of central government

It is necessary for government to take a lead in order to overcome many of the blockages which to date have prevented the delivery of adequate housing services to older people. These include placing requirements on Directors of Public Health and on health and local authorities to identify need, set objectives and monitor outputs and outcomes in relation to these objectives.

In addition, central government needs to have access to the findings of high quality and sophisticated research at local level, in order to inform its policies. Policies need to be coordinated across government departments and balanced in the sense that they reflect *local views and circumstances*, as well as striving for equitable national standards which are sensitive to the political significance of particular services.

Much of this work could be coordinated by the Minister for Public Health.

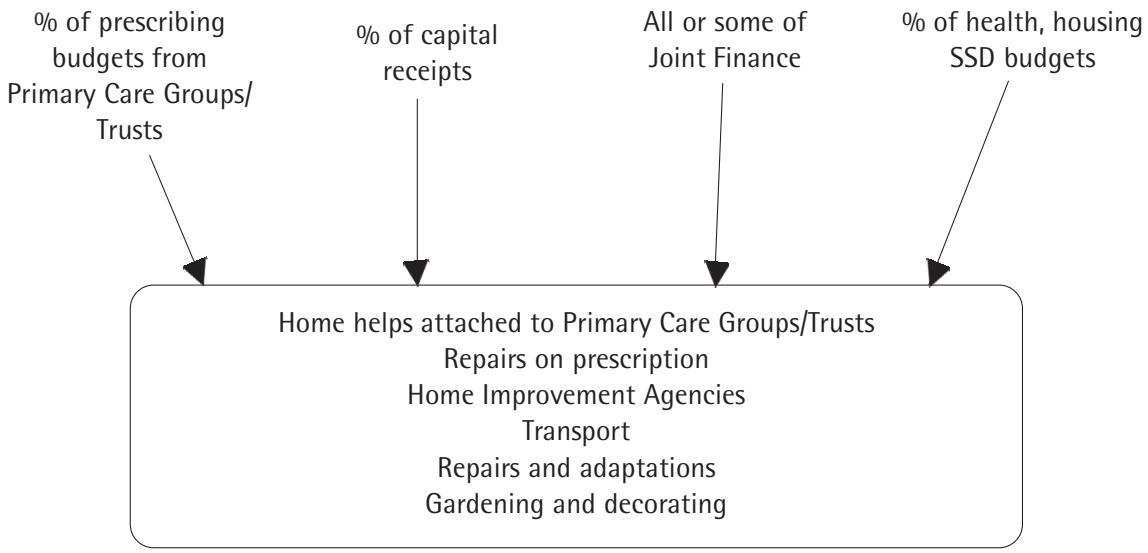
Providing the resources for additional services (Remedy 5)

In order to deliver equitably the services needed by older people in their own homes, additional public sector finances will be required. This would be extra to the money some older people would be able to contribute themselves to the cost of the services. Since it is unlikely that additional money will be made available from the Treasury, any resources will have come from shifts in existing budgets.

There are a number of agencies with mainstream budgets from which incremental shifts could be made. In addition, government could top slice certain streams of funding and 'hypothecate' a percentage of a budget towards housing services for older people. These possibilities are indicated below

Providing the resources for additional services

Agencies accountable to the Director of Public Health for allocating this from mainstream budgets



processes. This would be dependent on the Director undertaking the duties and functions outlined earlier.

We strongly agree with the recent government proposal that Joint Consultative Committees and Joint Finance should be abolished. Joint Finance has served as a cul-de-sac, preventing the consideration of joint planning within mainstream budgets, and the allocation of resources according to the scale of need. The system of allocation has been too inaccessible in many places. In others, where extensive consultation takes place, a huge resource of time and thought has been devoted to the allocation of a very small budget. This effort would be more usefully spent within mainstream planning, or allocated to a single agency managing an integrated budget. Moreover, the agencies which have a responsibility for addressing the housing impact on health should not be restricted to health, housing or social services. Relevant actions may also be taken, for example, by planning, leisure and transport departments.

Remedy 6: Making housing needs visible

A wide range of interrelated activities will need to take place, gradually building momentum over time, to establish the provision of these services to older people in their own homes as a priority. 'Consciousness raising' has to take place at a number of levels. These include:

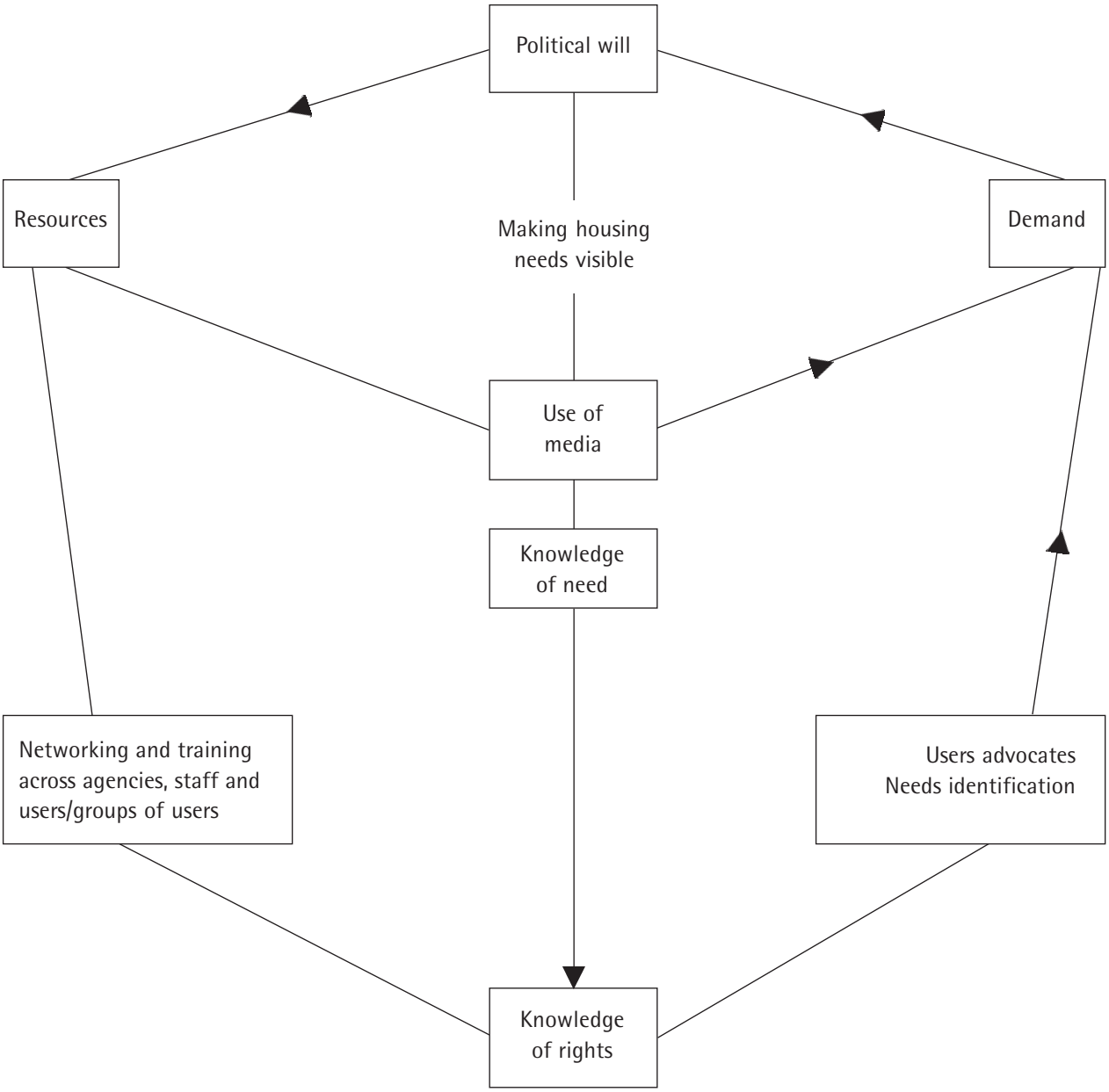
- nationally as political issue
- individually by older people
- among communities locally
- within front-line staff
- within managerial and professional cultures
- within planning processes.

Some of these developments can be prompted by:

- training programmes
- the exchange of information between different professional groups, and between managers involved in planning and front-line staff and users
- more visible needs assessment, coordinated by Directors of Public Health
- urban regeneration programmes and initiatives
- greater publicity and advocacy and the media taking up the issue.

In turn this would lead to older people themselves becoming aware of the availability of these services and professionals working with them being able to provide them with relevant information or acting as their advocate. This process is illustrated overleaf.

Making housing needs visible



7

The new policy context

Figure 8 lists key policy documents produced since 1996. It illustrates the extent to which government and key professional bodies are already proposing and supporting developments which link health and housing and also highlights some documents which have not been explicit about this link.

All are based, however, on the assumption that care at home is usually preferred by older people. It is interesting to note the other critical themes that run through so many of these documents: consultation with older people; preventative services; and joint working.

We hope that our analysis will be seen as making a useful contribution in this emerging policy context.

Figure 4: Prevalence of relevant themes in key policy documents

Theme	Consultation with older people	Preventive services a priority	Joint working	Panoramic needs assessment	Housing issues addressed	Transfer of funds
Better services for vulnerable people (DoH, 1997a)			■	■		
Building a better Britain for older people (DSS, 1998a)	■	■	■	■	■	
The coming of age (Audit Commission, 1997)	■	■	■	■		
Home alone (Audit Commission for Local Authorities and the NHS, 1998)	■		■	■	■	
Independent Inquiry into Inequalities in Health (Acheson, 1998)	■	■	■	■	■	
Modernising health and social services (DoH, 1998a)		■	■	■	■	
Modernising social services (DoH, 1998b)	■	■	■			■
A new approach to social services performance (DoH, 1999)	■	■	■		■	■
The new NHS: Modern, dependable (DoH, 1997b)	■	■	■	■		
Primary Care Groups (see DoH, 1997b)						
Health Improvement Programmes (see DoH, 1997b)	■		■	■		
Health Action Zones (see DoH,1997b)	■	■	■		■	■
Our healthier nation (DoH, 1998c)	■	■	■	■	■	
Partnership in action (DoH, 1998d)	■	■	■	■		■
Quality Protects (Three-year programme from 1998)			■	■		
Royal Commission on Long Term Care (1999)	■	■			■	■
Strengthening the public health function (NHSE, 1998)	■		■	■	■	
Supporting people (DSS, 1998b)		■	■			

8

Conclusion

We have argued in this report that the housing and housing services needs of older people are not being addressed systematically through any of the mainstream planning processes associated with health, housing and community care. We recognise that there are some fundamental structural problems, operating at societal and institutional levels, which prevent these needs being acknowledged and met. These blockages in turn lead to a lower hierarchy of problems which operate within the policy environment.

We feel, however, that given the emerging policy context, and the existence of most of the key parts of a system which could deliver the housing services needed to promote the independence of older people, it is possible to conceptualise a vision for the not too distant future.

The heart of this vision is the collection and coordination of information from two key sources, older people themselves and the front-line staff who routinely have access to older people in their own homes. The coordination, championing and monitoring needed to be associated with the planning of housing services we propose should be undertaken by Directors of Public Health. We also envisage central government, through the relevant departments, taking on new roles to ensure these needs are met. We also identify existing streams of finance from which modest shifts could ensure appropriate resources to meet the level of need.

The implementation of this vision would contribute to improvements in the mental and physical well-being for some of the very large number of older people living in their own homes. The approach is totally supportive of the national policy goals of fighting social exclusion; increasing independence; shifting towards preventative work and away from crisis intervention; involving users and promoting user involvement; and joint working across agencies and professionals.

We would welcome discussions with and feedback from policy makers, planners, politicians, civil servants, managers and professionals on their views of the feasibility of our vision and the ways in which it could be developed to render it more likely to be effective.

Author contact:

Frances Heywood/Lyn Harrison
School for Policy Studies
University of Bristol
Bristol BS8 1TZ

Tel: +44 (0)117 954 6755
Fax: +44 (0)117 954 6756
e-mail: sps-enquiries@bristol.ac.uk
http://www.bristol.ac.uk/Depts/SPS

Postscript: the examples transformed

Home Improvement Agencies universally available and well advertised. Budgets for Home Repairs Assistance available.

A single woman retires from work and finds her income halved while her housing costs have more than doubled. She is sick with both cold and worry. At her GP's she sees an advertisement for an agency that offers help with housing problems. This is no longer a matter of chance. Government has made resources available to ensure an adequate network of enhanced Home Improvement Agencies throughout the country and has increased housing grant resources to local authorities, so that the Home Improvement Agencies can advertise widely. The Home Improvement Agency worker is able to give the woman time, and then to help her apply for Income Support, Council Tax Rebate and Home Repairs Assistance. The house is repaired and made warmer and more energy efficient. The Home Improvement Agency then asks the woman whether she would like to join in with their drama group. She goes along, enjoys it, becomes a lynch pin and because she is out of the house more, her heating bills go down again. She does not need admission to hospital.

Jointly commissioned rapid response housework and bathing services, flexibly available. Bathing adaptation improved through research.

A disabled woman aged 70 approaches social services for help with bathing her 93-year-old mother and for occasional help with housework and shopping when she herself is unwell. The Director of Public Health in her area has previously persuaded the Health and Social Services Authorities of the benefits of jointly commissioning a preventative housework service for older people. This includes a 'rapid response home help team' which will take self-referrals from people who do not yet want permanent help. The woman is told that she can call on this service whenever she needs it.

The Director of Public Health has also drawn the attention of the Health and Social Services Authorities to research demonstrating the physical and mental health benefits of bathing to older people. As a result, a domiciliary bathing service has been jointly commissioned. The bath assistants see that an adaptation would make their task easier. The quality of these has been dramatically improved, and the cost reduced, as a result of research commissioned nationally by the DETR. After the adaptation, only one bath assistant is needed. Mother and daughter live on in their home until the mother dies peacefully, shortly after her 100th birthday, having seen in the millennium and received a message from the Queen.

Routine housing checks through GP referral. Repairs on prescription. Director of Public Health coordinates renewal plan, Primary Care Group includes environmental health officers.

A man of 72 goes to his doctor with bronchial problems. As a matter of what has become normal routine, the GP asks a health visitor to make a home visit and check the housing conditions. When she reports back on the terrible conditions, the GP refers the man to the local housing grants department for repairs on prescription. In the meantime, the health visitor contacts the environmental health officer who is attached to the Primary Care Group and together they visit some more homes in that block and make a joint report to the Director of Public Health. As a result of her intervention, the housing and health authorities jointly commission housing renewal in the area, thereby improving the health, family life and educational opportunities of many of the residents and those who will come to live there in the future, reducing year in year out demand on doctors' time, drugs and hospital budgets.

The power of government to shape practice

Government promotes a programme of health and support through quality housing design.

The Ministers for Health and for the DETR visit a housing cooperative together. *[This is a real example, already in existence: it was founded in the 1970s by an architect and some of his neighbours.]*

A mixed development of two-storey terraces was built, containing sheltered flats and general family housing. In the sheltered flats, space standards are generous, doors wide and the ground floor flats have level access thresholds. If any ground floor tenant becomes disabled or needs to use a wheelchair, only minimal adaptations are needed, so hospital discharge, where this is relevant, is not delayed. The windows of each flat are low, and look out onto courtyards where people come and go through the day, and which are a mass of flowers, some tended by the cooperative, some by the tenants. The courtyard design provides natural surveillance and security and neighbours in the general needs housing back up the support and company that is offered by the warden and by the common room facilities.

The heating system in the flats is quite efficient and cheap, and insulation good. Tenants stay warm, comfortable and healthy and are able to use money that might otherwise go on heating to pay for home helps if they need them. The flats are so popular that there is a long waiting list and the cooperative loses no rental income through having void property. Also, because the properties were well designed and

well built, the costs of maintenance and repairs are kept to a minimum and rent money can be used to pay for improvements. Thus housing contributes to the health, well-being, safety and security of the residents and reduces the need for input from health or social services.

The ministers become convinced of the long-term wisdom of commissioning good quality housing likely to enhance the health and quality of life of older people as well as producing exceedingly efficient use of stock. Policies are put in place to ensure that many more such cooperatives may be locally set up and empowered with loans to build well insulated, energy efficient and sociable housing with Lifetime Home features, that will repay the building costs over a 30-year period and then continue as an asset.

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