COMMENTARY

Housing and health care for older people

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Abstract

There is an enormous impact of home conditions both on the health of an older person living with a long-term illness, and their ability to remain independent in the face of disability. Geriatricians are often called upon to give advice to older people with a new illness about where to live. It is important therefore that they should understand the relationship between housing and health, and how to signpost patients and their families to advice on housing options. Vulnerable older people are more likely to be living in non-decent homes, generally private rented or owner-occupied. A new UK government initiative, Lifetime Homes, Lifetime neighbourhoods, offers the prospect for improvements in Home Improvement Agencies, Lifetime Homes Standards, and Disabled Facilities Grants.

Keywords: housing, health care, tenure, elderly

The link between housing and health

In 1842, Chadwick established the link between the appalling housing conditions of the poor and their poor health. The main health conditions with an identified causal link to housing have recently been summarised [1], and include respiratory conditions, ischaemic heart disease, cerebrovascular disease, accidents (e.g. falls, burns), infectious diseases, mental ill health and some cancers. Extensive research into the links between housing and health also underpin the government’s national Housing, Health and Safety Rating Scheme for assessing hazards in housing [2].

The relationship between poor housing and ill health is most clearly seen in older people: they have the highest prevalence of long-term conditions, and those over 85 spend 90% of their time at home [3]. Older people are the most vulnerable to the ill effects of poor housing and are the age group most likely to occupy poor housing.

It is well understood that public health interventions on sanitation led to improvements in health, but more recent evidence quantifying the savings to the NHS and social services resulting from specific investment in housing improvements is lacking. Relationships between housing and health are complex and multifactorial, and thus devising a methodology to accurately measure the health benefits and cost savings of interventions in the home environment is challenging [4].

Some conditions have been subject to closer examination. Hypothermia remains a significant problem: excess winter
deaths in the UK are far larger than that experienced in other countries with more severe winters [1]. Indoor temperature and markers of thermal efficiency of dwellings, including property age, are associated with increased vulnerability to winter death from cardiovascular disease [5]. A survey in Dundee found hypothermia in 5% of patients over 65 presenting to casualty departments, of whom 71% lived at deprived postcode addresses [6].

Home hazard reduction can be effective in reducing falls-related injuries when targeted correctly [7]. Better design of homes and neighbourhoods can enable people with dementia to live independently for longer.

An international literature search of the evidence base for the provision of housing adaptations and equipment for disabled people concluded that these did produce savings to health and social care budgets but that further research was needed to quantify impact [8]. Clearly, there is a ‘need for more systematic research within a wider social context to define which housing interventions are effective’ [9].

There is also a need for a change in approach by health, housing and social care professionals in order to facilitate holistic needs assessment and improve patient care. The national housing charity Care & Repair, England, has sought to encourage joint working and to raise awareness of the impact of housing on health through ‘Healthy Homes’ training for front-line staff [10]. Evaluation [3] of the impact of training concluded that whilst staff awareness of health and housing links was important, this was more effective in terms of impact on patients where there were jointly agreed outcomes, priorities and service commissioning arrangements across health, housing and social care.

**Trends in housing, tenure and condition**

A radical change in housing tenure has taken place in recent decades. Owner occupation is now the primary form of tenure, accounting for 70% of all households compared with 50% in 1970. Just over half of all low-income households are owner occupied. Among younger retired people, the owner occupation is nearly 80%. Around 5% of people over 65 years live in sheltered accommodation and another 5% in residential or nursing care homes.

The English House Condition Survey (EHCS), which started in 1996, provides an excellent review of the standards of housing, and includes definitions for non-decent homes and homes unfit for habitation (Table I). The latest published survey [11] shows that non-decent homes in the social sector have fallen from 52% in 1996 to 29% in 2006, primarily as a result of the multi-billion pound investment programme aimed at eradicating non-decent homes in the social sector by 2010. Housing under Registered Social Landlords (usually housing associations) has a lower rate of non-decent homes (23%) than Local Authority social housing (33%), while private rented housing has the highest non-decent rate of 41%. The majority of non-decent homes are owner occupied (3.8 m) [3]. One-half of non-decent homes fail on thermal comfort, while one-fifth fail on need for repair.

The definition of a ‘non-decent’ home excludes critical factors such as house design and risk of accidents. A better and higher standard has now been adopted through the Housing Health and Safety Rating System [2], and will be used by the EHCS in reports from 2006. It grades dwelling conditions on the basis of the likelihood and consequences of 29 risk factors.

Sadly, vulnerable (as defined by low income) households, including those with older people, are more likely to be living in non-decent homes: 58% of vulnerable households living in private-rented homes are in non-decent homes, and 38% living in owner-occupied homes. A third of vulnerable people over 75 years live in non-decent housing.

There is growing inequity in the older population between those with good income who live in their own homes and can afford maintenance, and those with low incomes often living in non-decent homes, and unable to afford maintenance and adaptation.

**Future policy developments**

In 2008, the government launched *Lifetime Homes, Lifetime Neighbourhoods—A National Strategy for Housing in an Ageing Society* (LHLN) [12]. This extensive report includes a thorough summary of the current and future projected situation with regard to housing and population ageing. It has made wide-ranging recommendations for action, and key areas are described here.

**Making choices about where to live**

Choosing where best to live in older age can be a complex decision, critically dependent upon access to wide-ranging information and available options. The decision is complicated by inter-related issues of finance, social support and care. Many older people are forced into over-hasty decisions following an illness and hospitalisation.

LHLN has recommended a combination of a national information service along with the provision of local specialists in housing advice and ‘moving home’ services. Current services vary considerably across localities, and no comprehensive joined up approach is evident. The ideal of course is to create a seamless service with integration of health, social care and housing. It is unclear how the aspiration of LHLN to ensure provision of ‘personal, immediate, coherent and

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**Table 1. Definition of home standards.**

<table>
<thead>
<tr>
<th>Unfit for habitation</th>
<th>Decent home</th>
</tr>
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<tbody>
<tr>
<td>Structurally unsafe</td>
<td>Passes the fitness standard</td>
</tr>
<tr>
<td>Severe dampness</td>
<td>No major repair to structure</td>
</tr>
<tr>
<td>No fresh water supply</td>
<td>Efficient heating</td>
</tr>
<tr>
<td>No water drainage</td>
<td>Efficient insulation</td>
</tr>
<tr>
<td>Inadequate ventilation</td>
<td>Reasonably modern facilities</td>
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comprehensive’ information, including finance information and care options, will be achieved everywhere, but as a first step, funding is being provided to support a new national advice service, FirstStop Advice.

Home repairs and minor adaptations
LHLN acknowledges that for older people, maintaining your own home and making adaptations to accommodate disability are crucial to retaining health and independence. Yet these remain a major source of concern with worry about ‘cowboy builders’ or lack of money to meet costs. In the case of adaptations, the homeowner may experience long delays at each hurdle: an occupational therapist to visit; a grant to be awarded; and the work to be carried out (see below). Linked to delivery of the strategy, the government is providing £33 million for small repairs and minor adaptations services with a direct grant going to every top tier local authority. Determining how the money is used is being left to local areas to decide, but joint commissioning by health, housing and social care is encouraged. There may therefore be an opportunity for doctors to influence use of this money to benefit older patients.

Home improvement agencies (HIAs) help homeowners and private sector tenants remain in their own home by advising on appropriate adaptations, assisting with grant applications, and either advising on a contractor, or doing the work through their own handyman service. There is an HIA in 90% of local authorities, but they vary greatly. There is considerable scope to improve their capacity, and their integration with routine health care for older people. LHLN proposes that HIA’s should be in the mainstream, far better integrated into social services and health, acting as the principal advocate for older homeowners needing home adaptation repair or housing advice.

The Warm Front Scheme offers free or low-cost energy efficiency home improvements such as central heating and insulation to low-income households. There remains a substantial need to deliver these improvements to private dwellings. Fuel poverty is an inter-related issue, and the rise in winter fuel payments may still be insufficient to encourage older people to accept central heating in the face of rising fuel costs.

Disabled Facilities Grants (DFG)
These grants are an entitlement for people who have disability and qualify financially for support. However, the process is bureaucratic, and delays deter many potential applicants as well as potentially causing delays in hospital discharge. A review of the DFG system identified multiple problems preventing the DFG system from having a wider impact. The strategy proposes a range of changes to the system and has increased the national funding levels year on year. Controversially, the DFG budget is no longer going to be ringfenced, and will be allocated via regions. This is designed to enable greater flexibility in the use of the DFG monies, and potential pooling with other budgets. One example is the potential recycling of stairlifts. The ceiling for grants has been increased to £30,000. Clinicians should be alert to whether current changes in their locality are leading to increased local budgets, less bureaucracy and a more responsive process.

Lifetime Homes Standards
In the UK, most homes have not been built with changing lifetime needs in mind. Yet most people prefer to continue living in their own home in the face of disability and ageing. Ideally this would become a more viable option if more homes were designed to be adaptable to disability, defined as meeting ‘Lifetime Homes Standards’ [13].

By 1996, only 3% of building companies had designed and built adaptable homes, and they viewed this as uneconomic [14]. As a result of the strategy, the government has determined that all new public sector housing must meet these standards by 2011, and expects the private sector to adopt these standards by 2013. Of course, it will take almost a century for the benefits of this to be fully realised, because of the rate at which housing is replaced. It is surprising that the industry may not have appreciated the business opportunity in building lifetime homes, when life expectancy and the number of older people living at home have been expanding so fast. The demand may grow as the public become more aware of the benefits of Lifetime Homes Standards.

Conclusions
Failure to address the housing needs of our ageing population will result in unnecessary higher costs in health and social care. Targeting the provision of advice and home improvements, including thermal comfort and adaptations, is critically needed, and should become part of mainstream geriatric assessment, through much improved working links with HIAs and other housing advisors. Geriatricians should ensure that their patients are offered all reasonable housing and housing support options to lead as independent and satisfying a life as possible.

Key points
- Relationships between housing and health are complex and multifactorial, yet are of considerable importance to an ageing population with multiple long-term conditions.
- Vulnerable older people suffer high rates of non-decent homes, the majority being owner-occupied residences or private-rented homes.
- Growth in the HIAs and the DFG is being planned: geriatricians should ensure that not only their patients receive a timely discharge but also that their housing needs are identified and met.
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Conflicts of interest

The author is a Trustee for the registered charity Care and Repair England.

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