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Housing for Health: Targeting housing mobility vouchers to help families with children

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In its recent call to action, the Robert Wood Johnson Foundation's Commission to Build a Healthier America noted that nearly a fifth of all Americans live in unhealthy neighborhoods that are marked by limited job opportunities, low-quality housing, pollution, limited access to healthy food, and few opportunities for physical activity, and that nearly half of black children live in particularly unhealthy areas of concentrated poverty.¹

Housing mobility programs provide vulnerable populations—including families with children—with resources to escape neighborhoods of concentrated disadvantage and move to neighborhoods of socioeconomic opportunity. These programs have the potential to improve population health and reduce health disparities by increasing access to health-promoting neighborhood amenities (e.g. grocery stores, safe recreational spaces, higher quality housing units), reducing exposure to chronic stressors (e.g. violence and crime), altering social networks, and achieving intergenerational increases in socioeconomic status and educational attainment. Prompted in large part by findings from the Moving to Opportunity for Fair Housing Demonstration (“MTO”), policy makers have begun to ask how to most effectively leverage the nation's housing programs to maximize health. Increasingly, attention has focused on using housing mobility to target young children.

MTO, a randomized controlled trial conducted in the 1990's, tested whether the offer of counseling, together with a housing voucher that could only be used in a low poverty census tract for the first year of its use, would lead to better outcomes, compared to a traditional housing voucher or remaining in public housing. In practice, the MTO counseling families received was modest, post-move counseling was not provided when families moved a second time (which was a common occurrence), and administrative barriers made it difficult to afford higher rents in opportunity suburbs. As a result, many of families who received a MTO voucher to move to a low poverty area did not relocate and, even among those who did, many returned to high poverty neighborhoods after a short period of time. Despite this, MTO demonstrated that the offer of a voucher to move to a low poverty neighborhood led to

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improved health outcomes including obesity, diabetes, and rates of physical exercise.² Recently, Kessler and colleagues found that girls from families who were offered a voucher to move to a low poverty neighborhood had, as adolescents, lower rates of depression and conduct disorders but boys had higher rates of depression, PTSD, and conduct disorders.³ The reasons for these counterintuitive findings for boys are the subject of on-going debate.

The MTO results underscore the challenges of using housing vouchers to move to, and then to stay in, neighborhoods of opportunity. The need for housing assistance far exceeds the available resources at the local, state, and national levels in the U.S. The Housing Choice Voucher program is the federal government's largest rental assistance program. It helps 2.2 million of the nation's poorest and most vulnerable households afford decent housing in the private market, at an annual cost of about \$19 billion.⁴ The program is an important federal investment designed to reduce worst case housing needs (i.e., the number of households living in substandard housing or experiencing financial hardship by paying more than half their income for housing costs) among very low income households.

Housing Choice Vouchers have been criticized for failing to expand access to quality housing for low income families in neighborhoods where jobs, transportation and high quality educational opportunities are greatest. Despite the buying power that the voucher provides, nearly half of the families using vouchers live in high poverty neighborhoods,⁵ and their children rarely have access to high quality educational opportunities.⁶ Black voucher participants have even greater difficulty translating this buying power into improved neighborhoods.⁷

MTO employed a powerful research design, but its health findings offer promise precisely because the "treatment" was a short lived and relatively weak intervention as compared to today's mobility counseling programs. Today's programs provide families with stronger supports for longer periods of time to overcome barriers to using vouchers in opportunity neighborhoods. The two largest mobility programs that are now operating, in Dallas and Baltimore, resulted from litigation settlements. In Baltimore, where disparities in life expectancy can vary by as much as 20 years depending on where one lives, over 2,400 families have chosen to move into racially integrated, lower poverty neighborhoods. With on-going post-move assistance, families typically stay in these new neighborhoods, or those that are similar, for many years. Across the nation, however, federal funding for housing mobility programs has been scarce and sporadic. Currently HUD funding for Housing Choice Vouchers covers the cost of the voucher but not the accompanying mobility counseling services that enable minority families to use the voucher to access higher opportunity neighborhoods.

Several key gaps must be filled to build support for mobility counseling to be combined with housing vouchers as a health promoting intervention. First, policy makers have suggested that the potential costs of operating mobility programs maybe offset by changes in health care spending over time. Currently, HUD and local housing agencies have little incentive to bear the costs of mobility programs on their budgets if the 'savings' accrue to health agencies. Rigorously quantifying the potential cost savings of housing mobility is an important step in better aligning health and housing policy goals and building an evidence

base for these agencies to jointly pay for mobility counseling as a potential health and wellness intervention.

Second, the optimal way to target mobility programs to obtain the biggest health return on investment remains largely unknown. The agency that oversees Baltimore's mobility program has recently adopted an early childhood preference, targeting housing vouchers and counseling services to eligible low income families with young children (0 to 8 years old) living in Baltimore City's poorest neighborhoods. Their reasons are explicitly health-related—evidence suggests that exposure to neighborhoods characterized by violence have a detrimental impact on brain development and long term health outcomes. Measuring health benefits and cost savings that accrue when a family with children moves to better housing in a safer and healthier neighborhood is critical. Additional research is necessary to determine whether mobility counseling might result in health benefits and cost savings for other vulnerable populations, such as those with preexisting diabetes and obesity.

At the same time, potential disruptions in health care may be especially salient for patients with preexisting health conditions if families move further away from their doctors or clinics. It is possible that providing counseling about health care resources in new neighborhoods may factor into families' decisions to move to specific homes and help ease their transition.

Finally, clinicians, health care systems, and insurers may play an important role in not only identifying individuals and families who may benefit from a referral to a housing mobility program but also supporting their health as they move. Health care reforms that promote population health management, such as accountable care organizations, may provide an impetus for collaboration with and financial support of mobility programs.

Evidence demonstrates that poor families living in the most disadvantaged neighborhoods are exposed to significant health risks. Such evidence also suggests that durable investments in housing programs that help low-income families find and afford housing in high-opportunity neighborhoods can improve health. Quantifying the potential health care savings is critical for aligning incentives and increasing funds to extend the mobility's reach.

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