Housing is now widely recognized to be an important social determinant of health (SDOH), with governments and nonprofit organizations seeing health improvement as a key byproduct of housing initiatives, and housing viewed as a valuable hub for coordinating services. In recent years, some large health plans have been investing in housing as part of their strategies to improve community health and development.

That is the good news. The bad news is that there are significant impediments to the goal of achieving the optimal level of investment in affordable housing as an SDOH by both the public and private sectors. Until these barriers are addressed, there will always be underinvestment.

The Challenge of Assessing the Effects

One impediment is the availability of data on outcomes. Public and private investment managers need good evidence of outcomes to sign off on proposed initiatives. Although there is better evidence on the effect of housing interventions than for most social determinants, evaluations of SDOH have been described appropriately as "sparse and mixed." Much more analysis is needed to understand fully the relationship between housing and health outcomes.

It is not just the volume of evaluations, however. Measuring the housing-health relationship is complicated. As Sherry Glied, PhD, an economist at New York University points out, correcting severe deficiencies in housing conditions can indeed alleviate ill health for some residents. But, Glied notes, it would be hard to show a sufficient return on investment (ROI) to justify investing in housing solely to achieve better health and reduced health costs; health benefits are better seen as a bonus alongside other benefits. So, one reason the evidence on housing's relationship with health seems mixed is that health "shares" an investment in housing with other outcomes, meaning that traditional ROI measurement can understate the housing-health connection. Using a broader social ROI analysis (SROI) takes into account the wider effects and typically indicates a larger total return.

Using an SROI approach whenever possible to evaluate the effects of housing on health would provide a more complete picture, indicating that only a portion of the investment should be considered when assessing the efficiency of the investment in producing the health effects. That has implications for how a housing-health investment might be financed. For example, consider a health plan investing in housing to improve the health of families experiencing homelessness. That investment would also be financing a portion of the local government’s objective of housing homeless people; an SROI analysis might thus suggest it would be efficient for the government to provide a financial offset for part of the plan's investment.

Coordinating Budgeting

Optimizing public investments in housing as an SDOH also requires governments at all levels to overhaul budgeting techniques so they can identify the cross-department budgetary effects of an investment in housing. The problem today is that investments by a housing authority typically yield savings to, say, Medicaid or Medicare (such as improved ventilation that reduces respiratory problems or safety upgrades that lead to fewer falls). But the housing budget and its managers typically receive no "credit" for those savings, and so housing budget managers do not have an

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incentive to implement such health-related investments. Known as the “wrong pockets” problem, the result is less than optimal public investment in housing initiatives that yield health benefits. A similar disincentive applies to investment in other social determinants, such as transportation and social services.

The solution to this widespread problem is for governments to explore more cross-department partnerships designed to improve collaboration and coordinate budgeting. The US Department of Health and Human Services has been a leader in these efforts. Late in 2021, for instance, the US Department of Health and Human Services and the US Department of Housing and Urban Development announced an expanded partnership and a Housing and Services Resource Center designed to coordinate cross-department strategies for people with disabilities, older adults, people experiencing homelessness, and other groups with needs. This partnership builds on generally good collaboration between the departments and was given a boost with funds from the American Rescue Plan Act of 2021. Some states have developed similar cross-department coordination. Vermont’s Support and Services at Home program, for instance, uses housing as a hub for a wide range of services for older adults and people with disabilities, and a 2019 evaluation indicated it yields significant Medicaid and Medicare savings.

Building Infrastructure

Strengthening partnerships across sectors and within communities requires a greater focus on fostering “connective tissue”—the infrastructure of data systems, trust-building structures, embedded intermediaries, financial reporting systems, and other shared elements needed for collaboration. That in turn requires a recognition that certain aspects of an SDOH strategy constitute a public good with benefits that are broad and collective in nature.

Although that public good feature underscores the importance of public investment, it also has important implications for private-sector financing initiatives. In particular, health plans need to recognize that even though they are competitors, it can be in their mutual interest, as some now appreciate, to shoulder jointly some of the public good infrastructure costs of housing-based partnerships in a community that yield improved health or savings—a business relationship known as “co-opetition.”

Targeted Government Actions

In addition, as with other efforts to address SDOH, governments can take targeted steps to foster health-related housing initiatives. For example, rules under the Fair Housing Act (designed to prevent discrimination in housing) unfortunately also raise legal worries for hospitals or health plans considering investing in housing-based strategies for their patients with chronic conditions. Limiting apartment availability in a building with health services to a plan’s enrollees could trigger a discrimination suit. Because of these concerns, the US Department of Housing and Urban Development should reexamine those rules to achieve a better balance of objectives. Meanwhile, the US Internal Revenue Service, which is responsible for nonprofit hospitals’ community benefit requirements, should include the financing of housing with wraparound services as a specific type of community benefit in its rules to remove uncertainty about whether it complies. Congress should also give Medicare and Medicaid greater authority to use funds for housing-based strategies.

This is a pivotal time for action on SDOH. There is a growing appreciation of the connection between housing and health, and an expansion in health systems’ investment in housing-focused interventions, with billions of dollars committed. But the evaluation evidence is not yet sufficient or well designed to determine with confidence that many initiatives are cost-effective, and government budgeting procedures and regulations undercut many promising approaches. Those
limitations and obstacles need to be addressed for housing to reach its full potential as a key component of better health.

REFERENCES
