

***A Prescription for a New Neighborhood?
Housing Vouchers as a Public Health Intervention***

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Introduction

The growing public health documentation of the health risks associated with high poverty, racially isolated neighborhoods¹ leads some housing and public health advocates to an inescapable conclusion: why can't we help at least some of these families voluntarily move to safer and healthier locations - perhaps prioritizing families with children most vulnerable to specific health risks?²

Although the answer may seem obvious, there is no current housing program that is designed to achieve this kind of targeted "health mobility." The Housing Choice Voucher Program (commonly known as "Section 8") is the closest program available, and yet it is vastly oversubscribed and has currently has no mechanism for prioritizing public health needs, or favoring placement of families in low poverty, healthier neighborhoods. Indeed, many of the program's features pull in the other direction.³ Some heavy lifting will be needed from the public health community, on both a policy research and advocacy level, to bring a vision of "health mobility" to fruition.

This report is an assessment of what public health, clinical, legal, and programmatic issues need to be addressed as we move closer to our vision of giving children with chronic health problems a "prescription for a new neighborhood."

We pose the question whether a change of "place" could lead to a significant health improvement for those individuals affected by these social and environmental determinants of

¹ David Williams, Michelle Sternthal & Rosalind Wright, *Social Determinants: Taking the Social Context of Asthma Seriously*, 123 PEDIATRICS (2009).

² See Dolores Acevedo-Garcia, Theresa L. Osypuk, Nancy McArdle & David R. Williams, *Toward A Policy-Relevant Analysis Of Geographic And Racial/Ethnic Disparities In Child Health*, 27 HEALTH AFFAIRS 321, 322 (2008); Gail Christopher, *Public Health and Housing Mobility*, in KEEPING THE PROMISE: PRESERVING AND ENHANCING HOUSING MOBILITY IN THE SECTION 8 HOUSING CHOICE VOUCHER PROGRAM, Philip Tegeler, Mary Cunningham & Margery Austin Turner, eds., (Poverty & Race Research Action Council), 2005.

³ See generally Philip Tegeler, *New Directions for U.S. Housing Policy: The Unmet Potential of Two Large Programs*, in THE EROSION OF RIGHTS: DECLINING CIVIL RIGHTS ENFORCEMENT UNDER THE BUSH ADMINISTRATION (Citizens Commission on Civil Rights), 2007.

health, drawing some preliminary conclusions about the potential health benefits from moving for families and children.

Finally, we will look to legal and policy literature to address both under what circumstances empowering families to move away from neighborhood health dangers is appropriate, and where appropriate, how such policies should be implemented, exploring the feasibility of policy ideas such as targeting some individuals as most likely to benefit from a move and prioritizing those moves. We conclude with questions that remain for advocates putting forward such a health proposal.

Geography and health

Geography serves as a primary means of concentrating and perpetuating disadvantage in our society, and patterns of government-supported racial and economic segregation constitute a leading cause of minority health disparities. Leading public health scholars recognize that neighborhoods play a crucial role in determining health outcomes:

The rapidly growing evidence on neighborhood effects finds that after taking into account individual-level factors, disadvantaged neighborhood environments (for example, poverty concentration) are associated with detrimental health outcomes, negative health behavior, developmental delays, teen parenthood, and academic failure. And although neighborhood conditions may influence health outcomes in all age groups, exposure to neighborhood disadvantage during childhood may be particularly harmful, as the effects of this exposure may continue into adolescence and adulthood.⁴

Most responses to the harms of housing segregation and concentrated poverty take the sensible and necessary approach of addressing economic and health disparities by working to improve the neighborhoods where poor families already live. However, PRRAC's work has also emphasized the importance of attacking metropolitan segregation directly, by desegregating metropolitan space. In our view, this strategy, which traces back to the beginning of the civil rights movement, is a necessary complement to neighborhood improvement strategies. This approach also respects the aspirations of those low income minority families who affirmatively want to move to less racially isolated and healthier neighborhoods with improved job opportunities and higher quality schools.

We believe that using voluntary housing mobility as a public health intervention can be an effective approach for the most at-risk children and can work in tandem with ongoing strategies to improve the quality of the environment in high poverty neighborhoods.

Recent research from a national five-city experimental housing mobility program ("Moving to Opportunity" or "MTO") shows that many participating low income families experienced improved physical and mental health outcomes when they moved to substantially lower poverty

⁴ Dolores Acevedo-Garcia, Theresa L. Osypuk, Nancy McArdle & David R. Williams, *Toward A Policy-Relevant Analysis Of Geographic And Racial/Ethnic Disparities In Child Health*, 27 HEALTH AFFAIRS 321, 323 (2008).

communities. In particular, adult obesity was “significantly lower among those who move.” Participants also experienced marked declines in psychological distress and depression.⁵ In part because of these findings, the potential of housing mobility has begun to be noticed by public health advocates working to address minority health disparities. For example, Dr. Gail Christopher of the W.K. Kellogg Foundation recently observed,

As the links between low socio-economic status, concentrated poverty and poor health outcomes become more widely understood, proponents for eliminating health disparities through public health interventions will see housing mobility as an important contextually based intervention strategy By enabling families to move from concentrated poverty to low poverty neighborhoods, many “mechanisms” of the socio-economic status-disease correlation are addressed.⁶

The aggregate health findings from MTO tend to mask the fact that for some of the families in the study, outcomes were extremely positive. How can such families be identified and “treated” with this simple intervention?

An Example: Asthma

Asthma is a chronic inflammatory disorder of the airways that can result in recurrent episodes of wheezing, breathlessness, chest tightness, and nighttime or early morning coughing.⁷ Over twenty-two million people are afflicted with the disease in the United States.⁸ This group includes over six million children, making asthma the most common chronic illness among children.⁹ Asthma is a leading cause of death in children and it is the most cited reason for missed school days, accounting for 33% of all missed days.¹⁰ Asthma is also the most frequent reason for childhood hospitalization.¹¹ In children and adults combined, asthma is the ninth leading cause of hospitalization.¹² Each year, 2 million American make emergency room visits for asthma.¹³

Asthma disproportionately afflicts “socioeconomically disadvantaged minority children who live in urban areas.”¹⁴ For example, in New York City, people in South Bronx, East and Central

⁵ Margery Austin Turner and Dolores Acevedo-Garcia, *The Benefits of Housing Mobility: A Review of the Research Evidence* in KEEPING THE PROMISE: PRESERVING AND ENHANCING HOUSING MOBILITY IN THE SECTION 8 HOUSING CHOICE VOUCHER PROGRAM, Philip Tegeler, Mary Cunningham, and Margery Austin Turner, eds., (Poverty & Race Research Action Council) 2005.

⁶ Christopher, *supra* note 2.

⁷ *The Impact of Policies on Breathing Easier*, 30 J.L. MED. & ETHICS 109, 109 (Supp. 2002).

⁸ Lara Akinbami, *Asthma Prevalence, Health Care Use and Mortality: United States, 2003-05*, (Nat'l Ctr. for Health Statistics, Ctrs. for Disease Ctrl. & Prev.), 2006., available at <http://www.cdc.gov/datastatistics/archive/asthma-absences.html>.

⁹ *Id.*

¹⁰ Env't Prot. Agency, *Cost of Asthma*, COST OF ILLNESS HANDBOOK, at 3, available at <http://www.epa.gov/oppt/coi>.

¹¹ *Id.*

¹² *Id.* at 10.

¹³ James Krieger & Donna L. Higgins, *Housing and Health: Time Again for Public Health Action*, 92 AMERICAN JOURNAL OF PUBLIC HEALTH 758, 758 (2002).

¹⁴ Env't Prot. Agency, *supra* note 10, at 23.

Harlem, and Central Brooklyn—all predominately low income neighborhoods of color—have much higher asthma rates than people in other city neighborhoods.¹⁵

Family income also correlates with asthma incidence.¹⁶ Generally, research shows higher asthma rates in low income communities because of neighborhood variables, including substandard housing, environmental hazards, inadequate health care access, and the insufficient wages and lack of job opportunities to be able to provide adequate health care access.¹⁷ Additionally, this substandard housing is marked by poor indoor air quality, with mold, mildew, dust, and cockroaches as likely triggers for asthma attacks. The causes and exacerbations of asthma in low-income communities of color are most often linked to poverty.¹⁸

Both home and neighborhood characteristics contribute to asthma risk. Living in heavily trafficked areas exposes children and families to air pollutants that can irritate the lungs.¹⁹ People of color are more likely to live in these areas than whites.²⁰ Even accounting for individual or behavioral factors like smoking, obesity, unemployment, or health status, neighborhood conditions with high pollutants were linked to asthma prevalence.²¹ Indoor air pollution, mold and dampness and cold, dust, and indoor pests also can contribute to asthma risk; however, researchers are also increasingly linking the experience of stress to asthma prevalence.²² In fact, children who hear gunshots may be more likely to experience asthmatic symptoms.²³

The MTO results showed that parents of children with asthma who moved to homes in higher opportunity neighborhoods rated their children's asthma as improved post-move, regardless of other risk factors.²⁴

¹⁵ Adam M. Karpati, Thomas Matte, D. Kass, Renu Garg, Farzad Mostashari, Lorna Thorpe & Thomas R. Frieden, *Asthma Can Be Controlled*, 2 NYC VITAL SIGNS (N.Y.C. Dep't Health & Mental Hygiene, New York, N.Y.), 2003, at 2, <http://home2.nyc.gov/html/doh/downloads/pdf/survey/survey-2003asthma.pdf>.

¹⁶ Env't Prot. Agency, *supra* note 10, at 6.

¹⁷ U.S. Dep't of Health & Human Servs., *Action Against Asthma: A Strategic Plan for the Department of Health And Human Services*, at 1, 7-9 (2000).; *see also* Gary Evans & Elyse Kantrowitz, *Socioeconomic Status and Health: The Potential Role of Environmental Risk Exposure*, in *THE NATION'S HEALTH* at 93, 97 (Philip R. Lee & Carroll L. Estes, eds., 2003) (linking asthma to the presence of cockroaches and pollens, particularly in low-income communities).

¹⁸ Alina Das, *The Asthma Crisis in Low-Income Communities of Color: Using the Law as a Tool for Promoting Public Health*, 31 N.Y.U. REV. L. & SOC. CHANGE 273, 276 (2007).

¹⁹ Ying-Ying Meng, et al., *Living Near Heavy Traffic Increases Asthma Severity*, UCLA CENTER FOR HEALTH POLICY RESEARCH (2006).

²⁰ *Id.*

²¹ Ying-Ying Meng, et al., *Are Frequent Asthma Symptoms Among Low-Income Individuals Related to Heavy Traffic Near Homes, Vulnerabilities, or Both?*, 18 UCLA CENTER FOR HEALTH POLICY RESEARCH, 343 (2008).

²² David R. Williams, *Social Determinants: Taking the Social Context of Asthma Seriously*, 123 PEDIATRICS 174, 175 (March 2009).

²³ Prevention Institute, *The Imperative of Reducing Health Disparities Through Prevention: Challenges, Implications, and Opportunities*, 6 (2006).

²⁴ Williams, *supra* note 22.

Policy Implications: A Prescription for a New Neighborhood

Research demonstrates that several conditions, such as asthma, are connected to neighborhood conditions. These include diabetes, nutrition and obesity issues, lead poisoning, and psychological distress. The creation of a set-aside voucher program aimed at children with these neighborhood-related conditions would be an important step towards addressing health disparities and towards providing families with a healthy home and community in which to raise their children. This program would feature:

- A special voucher program targeted towards children with specific health issues,
- HUD collaboration with HHS to ensure that the program achieves key health goals,
- Additional services offered to families to maintain stability and well-being, and
- Local administration of the health voucher program in coordination with the city or county health department.

There are precedents for such a program. HUD has already created voucher programs designed to address the needs of specific populations; children with chronic health conditions are among the most vulnerable to conditions arising from unhealthy surroundings and thus, the most likely population to benefit from moving to safer, healthier areas. There is also precedent for voucher programs that target placements in specific geographic locations. Finally, there is precedent for HUD collaboration on programs with other agencies.

A. Precedent for voucher programs targeted to specific populations

HUD has several specialized Section 8 voucher programs that target specific populations, including adults with disabilities, families, veterans, and individuals suffering from AIDS.

The Housing and Services for Homeless Persons Demonstration is a new targeted program in the HUD 2011 budget that would provide special vouchers and social services for adults with disabilities who are homeless or at risk of becoming homeless as well as families who are homeless or at risk of homelessness.²⁵ Vouchers would be distributed through competitive grants to Public Housing Agencies (PHA) that partner with health, human service and education agencies to address the needs of homeless individuals and families.²⁶ Funding for homeless persons with disabilities would provide vouchers targeting low income, single childless adults who are homeless and currently enrolled in Medicaid, using Housing Choice Vouchers and health, behavioral health, and other services to help individuals move and remain in permanent supportive housing.²⁷ Families will benefit from a combination of HUD assistance, Temporary

²⁵ U.S. Dep't of Hous. & Urban Dev., *Two Cross-Agency Initiatives to Help End Homelessness: Housing and Services for Homeless Persons Demonstration*, (presentation), http://portal.hud.gov/portal/page/portal/HUD/fy2011budget/signature_initiatives/homeless_persons_demonstration/Housing%20and%20Services%20for%20Homeless%20Persons%20Demonstration-.pdf.

²⁶ U.S. Dep't of Hous. & Urban Dev., *Department of Housing and Urban Development Overview of New and Cross-Cutting Initiatives: Housing and Services for Homeless Persons Demonstration*, (presentation), <http://www.hud.gov/offices/cfo/reports/2011/cjs/has-homeless-demo2011.pdf>.

²⁷ *Id.*

Assistance for Needy Families (TANF) support, as well as additional support services such as child care, health care, employment/job training, and educational support.²⁸

The Family Unification Program provides vouchers to approximately 16,000 families for whom the lack of adequate housing is a primary factor in the separation, or threat of imminent separation, of children from their families or in the prevention of reunifying the children with their families.²⁹ Family unification vouchers enable these families to lease or purchase decent, safe and sanitary housing that is affordable in the private housing market. The program is operated in collaboration with state and county welfare agencies. Families are eligible for these vouchers if they meet two conditions: 1) The public child welfare agency (PCWA) has certified that this is a family for whom the lack of adequate housing is a primary factor in the imminent placement of the family's child, or children, in out-of-home care, or in the delay of discharge of a child, or children, to the family from out-of-home care; and, 2) The PHA has determined the family is eligible for a housing choice voucher.³⁰

The HUD-Veterans Affairs Supportive Housing Program combines HUD Section 8 rental assistance for homeless veterans with case management and clinical services provided by the Veterans Affairs at its medical centers and in the community.³¹ Case managers at local Veterans Affairs Medical Centers (VAMC) are responsible for determining eligibility and referring eligible homeless veterans to the PHAs.³² Beneficiaries are selected based on certain requirements including health care eligibility, homelessness status, and income.³³ The program initially targeted veterans who were chronically mentally ill or had substance abuse disorders. This requirement was dropped in 2008; however, chronically homeless veterans remain a target population for HUD-VASH.³⁴ Participants receive assistance in identifying their social service and medical needs, regular ongoing case management, outpatient health services, hospitalization, and other supportive services as needed.³⁵

The Housing Opportunities for Persons with AIDS (HOPWA) program, housed in the Office of Community Planning and Development in the U.S. Department of Housing and Urban Development (HUD), addresses the housing and service needs of people living with HIV/AIDS.³⁶ HOPWA funds are awarded as grants from one of three programs: 1) the HOPWA competitive grant program, which funds approximately 20 projects sponsored by states, cities,

²⁸ Nat'l Alliance to End Homelessness, *Federal Policy Brief: FY 2011 Appropriations: Housing and Services for Homeless Persons Demonstration*, (March 23, 2010), available at <http://www.endhomelessness.org/content/article/detail/2690>.

²⁹ U.S. Dep't of Hous. & Urban Dev., *Family Unification Vouchers*, (April 22, 2003), <http://hud.gov/offices/pih/programs/hcv/family.cfm>.

³⁰ U.S. Dep't of Hous. & Urban Dev., *Family Unification Program*, <http://portal.hud.gov/portal/page/portal/HUD/programdescription/familyunification>.

³¹ U.S. Dep't of Hous. & Urban Dev., *HUD-VASH Vouchers*, (February 26, 2010), <http://www.hud.gov/offices/pih/programs/hcv/vash/>.

³² *Id.*

³³ U.S. Dep't of Hous. & Urban Dev., *Veterans Affairs Supportive Housing (HUD-VASH) Fact Sheet*, <http://www.hudhre.info/index.cfm?do=viewHudVashProgram>.

³⁴ *Id.*

³⁵ *Id.*

³⁶ U.S. Dep't of Hous. & Urban Dev., *Overview of HOPWA and Other HUD Housing Programs*, <http://www.hudhre.info/hopwa/index.cfm?do=viewHopwaOverview>.

local governments, and nonprofit organizations;³⁷ 2) the HOPWA Formula Program, which uses a statutory formula that relies on AIDS statistics from the Centers for Disease Control and Prevention (CDC) to allocate funding to qualified states and metropolitan areas with high rates of AIDS,³⁸ and; 3) The HOPWA National Technical Assistance Program, which provides funding to strengthen the management, operation, and capacity of HOPWA grantees, project sponsors, and potential applicants of HOPWA funding.³⁹ HOPWA programs provide “short-and long-term rental assistance, operate community residences or make use of other supportive housing facilities developed to address needs of persons who are living with HIV/AIDS.”⁴⁰ Grantees are encouraged to develop community-wide strategies and form partnerships with area nonprofit organizations.⁴¹ A large portion of HOPWA funds go toward tenant-based rental assistance.⁴² Eligible voucher recipients are low-income persons that are medically diagnosed with HIV/AIDS. In addition to housing support, HOPWA participants may also receive health care and mental health services, chemical dependency treatment, nutritional services, case management, assistance with daily living, and other supportive services.⁴³ During the 2008-2009 performance year, 95% of HOPWA clients receiving vouchers achieved housing stability.⁴⁴

B. Precedent for voucher programs targeted to placements in specific geographic locations

There have been a handful of voucher programs that feature geographically targeted destination neighborhoods for families.

Moving to Opportunity vouchers: Moving to Opportunity for Fair Housing (MTO) combines tenant-based rental assistance with housing counseling to help very low-income families move from poverty-stricken urban areas to low-poverty neighborhoods, serving as a 10 year research demonstration. Five public housing authorities—Baltimore, Boston, Chicago, Los Angeles, and New York City—administer the program, providing randomly selected experimental groups of families with housing counseling and vouchers that must be used in areas with less than 10 percent poverty.⁴⁵

Gautreaux, Walker, and Thompson vouchers: These housing mobility programs, in Chicago, Dallas, and Baltimore, all use geographically targeted vouchers that were initiated as part of remedial court decrees. The Gautreaux Assisted Housing Program issued tenant-based vouchers between 1976 and 1998 to over 7,000 families moving into racially targeted areas. Gautreaux

³⁷ U.S. Dep’t of Hous. & Urban Dev., *HOPWA Competitive Program*, (June 22, 2010), <http://www.hud.gov/offices/cpd/aidshousing/programs/competitive/>.

³⁸ U.S. Dep’t of Hous. & Urban Dev., *HOPWA Formula Program*, (October 6, 2009), <http://www.hud.gov/offices/cpd/aidshousing/programs/formula/>.

³⁹ U.S. Dep’t of Hous. & Urban Dev., *HOPWA National Technical Assistance*, (September 30, 2009), <http://www.hud.gov/offices/cpd/aidshousing/programs/technical/>.

⁴⁰ U.S. Dep’t of Hous. & Urban Dev., *HIV/AIDS Housing*, (March 30, 2010), <http://www.hud.gov/offices/cpd/aidshousing/>.

⁴¹ *Id.*

⁴² U.S. Dep’t of Hous. & Urban Dev., *HOPWA Competitive and Formula Grants: National Performance Profile*, (March 30 2010), available at <http://www.hud.gov/offices/cpd/aidshousing/>.

⁴³ U.S. Dep’t of Hous. & Urban Dev., *Housing Opportunities for Persons with AIDS (HOPWA) Program*, (March 22, 2010), <http://www.hud.gov/offices/cpd/aidshousing/programs/index.cfm>.

⁴⁴ U.S. Dep’t of Hous. & Urban Dev., *supra* note 42.

⁴⁵ U.S. Dep’t of Hous. & Urban Dev., *Moving to Opportunity for Fair Housing*, <http://portal.hud.gov/portal/page/portal/HUD/programdescription/mt0>.

did not provide employment, transportation, or any other assistance to participating families.⁴⁶ The Walker Program began providing vouchers in 2002. Over 2500 Walker Program participants receive vouchers that provide the opportunity to move to areas that are racially and economically targeted.⁴⁷ Along with the voucher, families receive first-time move assistance and other support. Since 2002 The Thompson Special Mobility Housing Choice Voucher Program has provided vouchers for 1,522 families to move to neighborhoods with lower concentrations of poverty and government assisted housing and greater ethnic diversity than the regional average.⁴⁸

Other geographically targeted housing programs: Other types of geographic targeting by mobility programs include school criteria, neighborhood quality indices, and assisted housing concentration.⁴⁹ Of course, most HUD housing programs are geographically targeted by design, requiring residents to accept a particular location as a condition of receiving federal housing assistance.

C. Precedent for HUD-HHS collaborations

Housing and Services for Homeless Persons Demonstration: The Housing and Services for Homeless Persons Demonstration can serve as a model for a program involving collaboration between HUD and the Department of Health and Human Service (HHS). The demonstration would receive funding from HUD's Section 8 Housing Choice Voucher program combined with services provided through Substance Abuse and Mental Health Services Administration (SAMHSA), Medicaid, and the Temporary Assistance for Needy Families (TANF) program within HHS.⁵⁰ This is part of an ongoing partnership between HUD and HHS "to better connect housing and services for those who need them."⁵¹

HOPWA: While HOPWA is funded and administered entirely by HUD, over 90 percent of grantees link the program with services from the HHS Ryan White CARE Act program to provide participants with a range of housing, health care, and support services. According to a national evaluation of the HOPWA program, coordination between HOPWA grantees and Ryan White CARE Act grantees is one of the biggest determinants of success.⁵²

D. Next Steps

⁴⁶ Micere Keels et al., *Fifteen Years Later: Can Residential Mobility Programs Provide A Long-Term Escape from Neighborhood Segregation, Crime, and Poverty?* 42 DEMOGRAPHY 51, 51–73 (2005), available at http://www.gse.uci.edu/person/duncan_g/docs/fifteenyearslater.pdf.

⁴⁷ Elizabeth K. Julian & Demetria L. McCain, *Housing Mobility: A Civil Right*, in THE INTEGRATION DEBATE at 89-90 (Chester Hartman & Gregory D. Squires, eds., 2009).

⁴⁸ Metropolitan Baltimore Quadel, *About Us*, (2010), <http://mbquadel.com/AboutUs.aspx>.

⁴⁹ See Mary Cunningham et al, *Improving Neighborhood Location Outcomes in The Housing Choice Voucher Program*, WHAT WORKS COLLABORATIVE and URBAN INSTITUTE (Forthcoming 2010).

⁵⁰ Nat'l Alliance to End Homelessness, *FY 2011 Appropriations: Housing and Services for Homeless Persons Demonstration*, (March 23, 2010), <http://www.endhomelessness.org/content/article/detail/2690>

⁵¹ U.S. Dep't of Hous. & Urban Dev., *Housing and Services for Homeless Persons Demonstration*, http://portal.hud.gov/portal/page/portal/HUD/fy2011budget/signature_initiatives/homeless_persons_demonstration.

⁵² Dave Pollack, et al, ICF Consulting, *National Evaluation of the Housing Opportunities for Persons with AIDS Program (HOPWA)*, at V-2, (December 2000), http://www.huduser.org/publications/pdf/hopwa_0101.pdf.

In order to make this health mobility proposal a reality, there are both policy determinations to be made and pragmatic concerns to address in order to build a constituency for it. In order to build support for the proposed program, advocates need to justify the targeting of vouchers to an identifiable group. With so few housing vouchers to go around and such high demand, advocates will need to be able to distinguish the targeted recipients from other potentially deserving groups. This program would be unique in targeting children—a group that is particularly vulnerable to negative health impacts. Both their vulnerability and their resiliency when placed in new environments would be powerful arguments for a program targeting children.

Another challenge in promoting the program will be the need for combining health and housing interventions. This calls for interagency collaboration as well as collaboration among both housing and health advocates. Advocates of this proposal will certainly need to find a way to reach beyond silos in order to see this proposal become reality.

Possibly the most important consideration in building support for this program is developing a strong cost savings to justify the intervention. While advocates will agree that the program is worthwhile for its own sake, in order to make the program politically viable, we must recognize that—particularly in difficult economic times—the cost of the program matters. The importance of documented cost savings in justifying a health policy intervention is illustrated by the “Housing and Services for Homeless Persons Demonstration” in the HUD 2011 budget. Using data developed by researchers at the University of Pennsylvania,⁵³ HUD, in its budget justification memo, noted that the \$6899 per person cost of housing assistance resulted in savings of \$14,000 per person in social services health related costs (\$3270 in Medicaid, \$1402 in ER visits, \$4966 behavioral health services, and \$4366 detoxification services).⁵⁴ We believe similar savings estimates are possible for a health mobility program.

Most economic assessments of health interventions make broad society-wide estimates of the costs of different illnesses, and the overall cost savings associated with specific interventions. For example, the Surgeon General recently estimated the total cost of obesity in the year 2000 at \$117 billion - \$61 billion in direct costs (physician visits, hospital and nursing home care) and \$56 billion in indirect costs.⁵⁵ Another study, sponsored by the Joint Center for Political and Economic Studies, estimated the cost of minority health disparities between 2003 and 2006 in the range of \$1.24 trillion.⁵⁶ Similarly, in England, the Marmot review final report, *Fair Society, Healthy Lives* (February 2010) recently estimated the cost of health inequalities in England to include “additional NHS healthcare costs well in excess of £5.5 billion per year,” and indirect costs of £51-65 billion per year.

⁵³ Dennis Culhane, Stephen Metraux, & Trevor Hadley, *Public Service Reductions Associated with Placement of Homeless Persons with Severe Mental Illness in Supportive Housing*, 13 HOUSING POLICY DEBATE 107, (Fannie Mae Foundation), 2002.

⁵⁴ U.S. Dep’t of Hous. & Urban Dev., *Overview of New and Cross-Cutting Initiatives: Housing And Services For Homeless Persons Demonstration*, <http://www.hud.gov/offices/cfo/reports/2011/cjs/has-homeless-demo2011.pdf>.

⁵⁵ U.S. Dep’t of Health and Human Serv., *The Surgeon General’s Call To Action To Prevent and Decrease Overweight and Obesity 2001*, at 9-10, (Public Health Service, Office of the Surgeon General), 2001.

⁵⁶ Thomas LaViest, Darrell Gaskin, and Patrick Richard, *The Economic Burden of Health Inequalities in the United States* (Joint Center for Political and Economic Studies), Sept. 2009.

Cost/benefit analysis at the level of the individual is harder to come by. For example, it will require substantial additional research to estimate the cost savings of a move to a healthier neighborhood for a group of 4000 children with chronic asthma, lead poisoning, or obesity. In the homeless study cited earlier, Dennis Culhane and his colleagues did this kind of analysis for homeless adults with chronic illness or disability and found significant decreases in health costs resulting from placement in supportive housing facilities.⁵⁷

Some Policy Choices

A key question for advocates going forward with such a proposal is whom to target for voucher assistance. Which particular health conditions should be included, and which children should be presumptively eligible? In order to determine which health conditions ought to be addressed with vouchers advocates should look toward research that hints at the effects of a move on the particular conditions. For example, for any given condition, is there a point at which the damage has been done or is it cumulative over time? In shaping the policy, should a top age limit for children be imposed?

Another significant policy determination will be the manner in which families are selected. One leading possibility would be that they would be screened by a health professional for a particular health condition, following the HOPWA model. However, this model may be easier to implement for physical conditions than for psychological ones—while a specific diagnosis for asthma or diabetes is fairly straightforward, a diagnosis of psychological distress from living in a violent environment may be more challenging.

Finally, the appropriate range of supportive services will need to be defined. Should family health assessments and health improvement plans be part of each family's placement? Follow-up visits with a pediatrician and tracking of family health outcomes by the county health department should be considered.

Conclusion

The next opportunity for a demonstration health mobility proposal would be in HUD's 2012 budget, which will be developed starting in the fall and winter of 2010. PRRAC is now reaching out to colleagues in the public health field to help develop this concept into a mature legislative proposal. If you would like to help or have ideas for this proposal, please contact Kami Kruckenberg at kkruckenberg@prrac.org.

⁵⁷ Culhane, et al., *supra* note 52.