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ANALYSIS & COMMENTARY

Health In All Policies: The Role Of The US Department Of Housing And Urban Development And Present And Future Challenges

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ABSTRACT **The link between federal housing policy and public health has been understood since the nineteenth century, when housing activists first sought to abolish slums and create healthful environments. This article describes how the Obama administration—building on these efforts and those that followed, including the Great Society programs of President Lyndon Johnson—has adopted a cross-sector approach that takes health considerations into account when formulating housing and community development policy. The federal Department of Housing and Urban Development fully embraces this "health in all policies" approach. Nonetheless, the administration's strategy faces challenges, including fiscal and political ones. Some of these challenges may be overcome by conducting quality research on how housing and community development policies affect health outcomes, and by developing a federal budget strategy that takes into account how investments in one sector contribute to cost savings in another.**

The Affordable Care Act created an unprecedented opportunity at the federal level to focus on the social and economic determinants of health. The law's enactment constituted a turning point in federal health policy. Not only will it reform health insurance and expand coverage, but it also institutionalizes a "health in all policies"—or cross-sector—approach, which encourages policy makers to weigh the health implications of policies that are not normally considered health related.

The Department of Housing and Urban Development (HUD) has also embraced a health in all policies approach. HUD was created as a cabinet-level agency in 1965, a centerpiece of the Johnson administration's Great Society. Charged with providing housing and development assistance for the nation's communities, the department manages the Federal Housing Administration loan insurance program, operates the federal government's main rental assistance programs for low-income households, serves as a conduit for major community development grant programs, and enforces fair housing laws (Appendix Exhibit 1 shows funding levels for selected HUD programs).[1]

HUD's annual budget of nearly $50 billion provides substantial resources for influencing the social determinants of health. HUD can play a central role in this endeavor because its core mission is "to create strong, sustainable, inclusive communities and quality affordable homes for all."[2]

The fact that HUD is now so focused on health in all policies constitutes a marked change from past policies, and a recognition that new opportunities exist to advance the goals of public health through housing and community development policy.

This article begins by describing the historical background of US federal housing policy. It then describes HUD's current policies and activities and explains how this iteration of place-based policy innovation differs from prior efforts. It continues by describing the contemporary context for a health in all policies approach. The article closes with a discussion of challenges that the federal government faces in carrying out the logical implications of the health in all policies approach.

HUD And Health Policy: A Historical Perspective

The first calls for a federal housing policy in the United States came in response to the slums that emerged during the Industrial Revolution of the nineteenth century. Slums were thought to breed immorality, disease, and death, and it was believed that better housing would eliminate those ills.[3]

Between the 1800s and the early 1930s, housing reform consisted mostly of campaigns for building codes to enforce standards for safety and sanitation and the development of model housing projects. The Great Depression offered advocates of public housing opportunities to lobby for federal initiatives. These initiatives, including the low-income housing built by the Public Works Administration, paved the way for the Housing Act of 1937—the first major federal initiative to promote decent, affordable housing for low-income families. In the words of act, its goals included "the eradication of slums" and "the provision of decent, safe, and sanitary dwellings for families of low income."

In his 1949 State of the Union address, President Harry S. Truman rallied support for his housing proposals, proclaiming that "five million families are still living in slums and firetraps," a clear call to alleviate unhealthy and dangerous housing conditions.[4]

Still, throughout much of the twentieth century, the connections between health, housing, and communities were not in the foreground of housing and urban development policy. Instead, greater emphasis was placed on creating jobs, reducing unemployment, spurring economic growth, stimulating business activity, and increasing the supply of affordable housing. This remained true for Truman's administration and subsequent iterations of federal housing and community development policy.

HUD AND HEALTH TARGETS Following the department's creation in the 1960s, and increasingly into the 1990s, HUD explicitly addressed health issues in its programming. It initiated and expanded programs that targeted lead and other indoor environmental health hazards and that addressed the housing-related problems of medically vulnerable populations, such as the frail elderly, the homeless, people with HIV/AIDS, and the disabled.

For example, HUD's Office of Healthy Homes and Lead Hazard Control was established in 1991 and has targeted indoor environmental health hazards such as lead paint, mold, and unsafe and inaccessible design features. HUD's Lead Hazard Control Program, in conjunction with policies prohibiting lead in paint and gasoline products, has contributed to a 70 percent reduction in childhood lead poisoning since the early 1990s.[5]

PUBLIC HOUSING, 'MOBILITY' PROGRAMS, AND NEIGHBORHOOD REVITALIZATION Over the years, HUD partnered with states and localities in the construction of public housing, and over time the department came to incorporate health perspectives into these programs as well. Public housing programs began with great hope that the public sector would do a better job of housing low-income populations than the private sector. Yet a number of the federally funded housing projects built by local public housing authorities did not fulfill this promise. Many became isolated communities of concentrated poverty with severely distressed properties and high crime rates.

There were two basic responses to this failure: mobility and neighborhood revitalization. "Mobility" refers to programs that offer people the opportunity to move out of distressed neighborhoods. The Section 8 voucher program, established in 1974, was the first such initiative. In 1999, it was renamed the Housing Choice Voucher program.[6]

To measure the effectiveness of the mobility concept, HUD initiated its Moving to Opportunity for Fair Housing Demonstration program in 1992. The goal was to produce rigorous experimental data about the effects of using vouchers to move residents out of public housing in impoverished neighborhoods and into more affluent neighborhoods. The program did not demonstrate the hypothesized economic benefits for voucher holders. However, it did result in positive health outcomes, including reductions in psychological distress, depression, and obesity among adults, and mental health improvements among girls.[7,8]

Neighborhood revitalization, the other response to the failure of public housing projects, also had mixed results. One key program for promoting neighborhood revitalization was HUD's Housing Opportunities for People Everywhere, or HOPE VI, which started in 1992. HOPE VI sought to replace severely distressed public

housing projects, inhabited solely by poor families, with new, attractive, mixed-income housing. The original goal was for public housing residents displaced by HOPE VI demolition to return to the new communities after redevelopment. However, a large share of displaced residents received vouchers, moved to slightly better neighborhoods, and did not return to public housing.[9,10]

A recent panel study of HOPE VI residents did not show improvements in self-reported health status.[11] However, there is evidence that displaced residents experienced decreases in anxiety and exposure to violence—a finding that may have positive implications for mental and physical health and well-being.[9,12] But the hypothesis that HOPE VI would have positive spillover effects on surrounding neighborhoods, including increased property values and decreased violent crime, has found only limited support in studies.[13]

THE OBAMA ADMINISTRATION AND PLACE-BASED BUDGETING While working to pass the Affordable Care Act, the Obama administration embarked on a "place-based budgeting" initiative that required each federal department and agency to consider geography when setting fiscal priorities. This initiative called for coordinated investment strategies that would support the "prosperity, equity, sustainability, and livability of neighborhoods, cities and towns, and larger regions...[by enabling] locally-driven, integrated, and place-conscious solutions."[14] The goal was to promote new funding across agencies to help communities address such interconnected problems as distressed housing, underperforming schools, neighborhood violence, inadequate public transportation, and poor health.

The Obama administration's placed-based budgeting policy spurred HUD to begin coordinating with other agencies to invest in communities that lack infrastructure and economic growth. Such interagency efforts include the Neighborhood Revitalization Initiative, the Sustainable Communities Partnership, and the Strong Cities, Strong Communities Initiative.

The convergence of these policy interests and goals created an opportunity for HUD to use housing and community development policy to improve population health. An example is Choice Neighborhoods, a relatively new HUD initiative that replaces HOPE VI. Choice Neighborhoods combines efforts to bring mixed-income redevelopment to distressed neighborhoods with an integrated, place-based approach to community development. This holistic approach includes coordinating with other federal initiatives that promote healthy lifestyles and healthy environments and improve access to quality education.

Health In All Policies: The Context

Today, federal policy makers can look back on a large and sophisticated body of research showing that social and economic factors heavily influence population health over the short and long term.[15–20] These factors, which include low socioeconomic status, concentrated poverty, and neighborhood quality, are referred to collectively as the social determinants of health.

For instance, neighborhoods of concentrated poverty often lack grocery stores with fresh food,[21] adequate public transportation,[22] and access to public space.[23] They are also often situated near environmental hazards.[24,25] Such conditions hamper residents' ability to eat healthy food, stay physically active, and engage in activities that build community—all of which can lead to improved population health.[26,27]

Impoverished neighborhoods also have markedly higher rates of violence and crime,[28,29] which are associated with elevated rates of mental illness;[30] risky health behaviors like smoking; negative cognitive impacts on children;[31] and chronic illnesses such as asthma, hypertension, and obesity.[32]

SOCIAL DETERMINANTS OF HEALTH The growing recognition of social determinants among policy makers around the world has prompted them to try to understand how they can take advantage of non–health sector policies to improve population health. For instance, they can advocate for transportation policies that encourage functional physical activity, such as walking or biking to work, and for street design and land-use patterns that increase levels of physical activity and foster community.[33,34]

Research into the relationship between social determinants and health has played a critical role in the international movement to adopt a health in all policies framework for improving population health. This approach to disease prevention and health promotion stemmed from decades of work, led by the World Health Organization, to establish connections between social conditions and health. Proponents of the approach have encouraged policy makers in federal and local agencies to think more broadly about the health implications of programs and initiatives that span multiple sectors and the need for the public health sector to engage across government.[35,36]

During the Finnish presidency of the Council of the European Union in 2006, for example, the European Union adopted health in all policies as its main health theme. The initiative called for an

examination of health determinants that mainly fell outside the purview of the health sector, with the objective of influencing policy making across Europe and at all levels of government.[37]

IMPLEMENTATION IN THE UNITED STATES Although the health in all policies concept has an international history going back to the 1970s,[37] the United States did not begin adopting it until 2010. The Affordable Care Act created the National Prevention, Health Promotion, and Public Health Council—the first concerted effort in US history to apply a health in all policies approach to federal policy.

Known as the National Prevention Council, it is chaired by the surgeon general. Falling within the jurisdiction of the Department of Health and Human Services (HHS), this body of cabinet-level officers from seventeen federal agencies is responsible for developing and implementing comprehensive cross-sector strategies to promote health and prevent disease.

The Affordable Care Act also called for preparation of a National Prevention Strategy, which was released in June 2011 by the National Prevention Council. The plan emphasized that housing affordability, housing quality and safety, and cross-sector collaboration in community planning and design are critical to improving population health and promoting health and safety.[38]

HHS said in a news release that "good health comes not just from receiving quality medical care, but also from clean air and water, safe worksites, and healthy foods,"[39] thus signaling the importance of coordinated investments to improve health, prevent disease, and optimize the wellness of the US population. According to the Institute of Medicine, this initiative constituted the "highest-profile Health in All Policies action in the federal government."[40]

The National Prevention Strategy's recognition of the critical influence of housing and urban development policies on population health represented a major shift from a narrow focus on medical care and services to a broader consideration of the social determinants of health in prevention and wellness policy. Moreover, this plan has the strong and active support of top federal public health officials, including the surgeon general—a key to the success of any health in all policies approach, according to the World Health Organization.[36]

Finally, the Affordable Care Act also established the Prevention and Public Health Fund, the first mandatory federal funding stream devoted to public health and focused on wellness promotion and disease prevention. The fund was designed to provide $15 billion of federal support over ten years for strategic cross-sector investments in prevention. Unfortunately, some program funds are being used to offset budget cuts to existing Centers for Disease Control and Prevention programs, limiting the usefulness of the fund to address other important public health needs. Moreover, Congress cut $6.25 billion from the fund to offset a portion of the cost of the Middle Class Tax Relief and Job Creation Act in February 2012.

HEALTH FOCUS IN HUD Notwithstanding these setbacks, health in all policies now permeates HUD's strategic plan and policy discourse. It constitutes a totally new way of thinking about community development policy in the United States.

HUD's 2010–2015 strategic plan explicitly links community development policy to health through two of its five goals. The first goal is to "utilize housing as a platform for improving the quality of life," with the subgoal of "utiliz[ing] HUD assistance to improve health outcomes." The second goal is to "build inclusive and sustainable communities free from discrimination," with the subgoal of "promot[ing] energy-efficient buildings and location-efficient communities that are healthy, affordable, and diverse."[41]

Mounting evidence supporting a link between community development policies and health have motivated new collaboration between HUD secretary Shaun Donovan and HHS secretary Kathleen Sebelius. These two leaders have orchestrated a shift from what had been ad hoc, staff-level interdepartmental collaboration on a program-by-program basis to broader, more consistent, and explicit programmatic and policy integration. Collaborative efforts range from healthy homes and lead hazard control to community integration for elderly and disabled populations (Fred Karnas, former senior adviser to HUD secretary Shaun Donovan and former HUD designee to the National Prevention Council, personal communication, March 31, 2012).

For instance, HHS and HUD now collaborate on the Housing Capacity Building Initiative for Community Living project, which spurs coordination between community housing agencies and human services agencies to help older adults or adults with disabilities access housing, medical, and support services. The goal of the initiative is to help people live as independently as possible for as long as possible, even as their functional needs change over time.[42]

One key element of this collaboration is a joint effort to inform state housing finance and Medicaid agencies about the HUD Section 811 Project Rental Assistance Demonstration program. Traditionally, Section 811 grants enabled housing and nonprofit agencies to build affordable housing and to couple that with supportive

services for people with disabilities. The new demonstration program awards HUD rental assistance subsidies to state housing agencies or other nonprofits that partner with state health and human services and Medicaid agencies.[43]

The secretaries' leadership has also spurred other approaches to health in all policies. For example, HUD's funding notices now encourage applicants for Sustainable Communities Regional Planning Grants and Choice Neighborhoods grants to incorporate health metrics into their baseline assessments of target neighborhoods. They are also asked to state how they will support regional planning efforts that consider public health and environmental impacts.[44]

In addition, Secretary Donovan has created a health council, which brings together staff from various HUD programs to discuss how health in all policies can be implemented and coordinated. This council goes a long way toward institutionalizing the health in all policies approach at HUD.

Challenges

Although leadership has played an essential role in the evolution and integration of the health in all policies approach at the federal level, many challenges to the full institutionalization of the approach remain. Among these are limited knowledge and lack of shared understanding at the staff level of the priorities and interests of HUD and HHS programs and the goals they intend to achieve. Furthermore, current collaborations and policy discussions do not explicitly call for studying the ability of housing and community development policies to control health care costs over time. Thus, there is likely to be a lack of cost-benefit information that could be of value to policy makers in the future.

In an economic and political climate that has brought substantial cuts to discretionary spending, HUD programs also face challenges. HUD's Sustainable Communities grant programs were not funded in 2012. Although they are included in the president's budget for 2013, they are likely to face opposition in Congress again.

Another major challenge is that the federal budget process impedes interagency collaboration, partly because congressional committees consider budgets for different sectors independently. The status quo of budgeting within predetermined silos creates barriers to investing in programs that are likely to show results in more than one federal spending category, even though those programs are likely to save the federal government money overall.

For example, increased HUD funding in housing and supportive services for the elderly may translate into reduced Medicaid costs by reducing nursing home admissions. However, HHS is unable to fund HUD programs. And because HHS, not HUD, would reap the cost savings, there is little incentive for Congress to make such investments using HUD-designated funds.

Efforts to counter the logistical limitations of current budgeting approaches might involve federal agencies—with consent from Congress—entering into memoranda of understanding to share savings and benefits from cross-sector planning. That said, we recognize that although cost savings are important, they are not always paramount. The need to save money should not outweigh the primary goal: for federal investments to achieve optimal outcomes for the US population.

Applying the health in all policies approach to housing and community development policy requires research in several areas, including the comparative effectiveness of various community investment programs in promoting health. Systems modeling and forecasting might be helpful in this regard. Applying the approach also requires the development of an evidence base about the role of neighborhoods in fostering good or bad health.

Integrated data sets are also essential for achieving the research goal, because they facilitate cross-field studies. HUD is working to develop two such data sets. For example, the National Center for Health Statistics, HUD, and HHS are combining administrative data to enable a national-level analysis of the health, wellness, and disability of renters receiving federal assistance. Another effort links HUD-assisted renters with Medicaid records.

Conclusion

Notions among federal policy makers about the interrelationship of community development and health have undergone a major transformation. HUD has adopted a health in all policies approach to policy making, policy reform, and program implementation that recognizes the implications of social and place-based determinants of health for the population that its programs serve.

But successful long-term implementation of health in all policies requires substantial institutional change, including a refocusing of goals, processes, and priorities at all federal agencies, including HHS. Success also requires a budgeting approach that considers how investments in one sector contribute to cost savings in another. Leadership is a key element, but this undertaking will also necessitate a more widespread transformation—at every level of government.

Despite the new openness to a health in all policies approach at HUD, the policy's long-term institutionalization, both at HUD and across agencies, remains tenuous. As described above, HUD needs to do more to achieve consistent implementation at all levels. Moreover, the effort to integrate health in all policies into federal policy making across a broader range of agencies is threatened by the challenging fiscal climate, the congressional push for deficit reduction, and the politicization of the Affordable Care Act. Another complication is the uncertain future of the Prevention and Public Health Fund.

Nonetheless, HUD's adoption of a health in all policies approach at the highest level of leadership is an important achievement. It signals HUD's embrace of the principle that HUD-related investments have implications for social determinants of health—and ultimately for the health of the populations HUD serves. ■

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NOTES

1 To access the Appendix, click on the Appendix link in the box to the right of the article online.

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In this month's *Health Affairs,* Raphael Bostic and coauthors describe how a long-understood link between federal housing policy and public health has evolved over the years into the "health in all policies" approach embraced across the federal government. However, the authors note that the approach faces considerable challenges, including fiscal and political ones. Among other recommendations, they suggest developing a federal budget strategy that takes into account how investments in one sector, such as housing, could contribute to health cost savings, as well as conducting the research that will help to establish the connection.

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