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AIDS, housing, and health

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There is a long tradition in Britain of using housing interventions to promote public health, beginning with the Public Health Act of 1848 and the Housing Acts of the late nineteenth century, which were all pre-occupied with disease control. Although the housing functions of the Ministry of Health were transferred to the Ministry of Housing and Local Government in 1951, the expansion of the public rented sector—a cornerstone of the welfare state—allowed local authorities routinely to shelter those whose market opportunities were undermined by poor health. By the time the Department of the Environment assumed ministerial responsibility for housing in 1970 the procedures for incorporating medical priority into housing allocations were well established.^{1,2} There is, nevertheless, a second housing and health tradition in Britain, grounded in the use of residential institutions to contain and control certain medical problems—to isolate infectious disease, manage psychiatric disorder, and service frailty or disability.^{3,4} These contrasting approaches to accommodating sick people—rooted, respectively, in the principle of disease prevention or health promotion and in the philosophy of containment and control—are a continuing source of tension within housing policy and practice.

Although deinstitutionalisation has gathered momentum since the 1950s, supposedly implemented hand in hand with the development of community care, the procedure has no explicit housing component, and no extra general needs, state subsidised housing was ever earmarked for it. On the contrary, since the end of the 1960s and especially since 1980 public housing—the key to adequate shelter for those whose health state inhibits their labour market opportunities—has been declining in significance. The council stock has diminished in size and quality and is becoming a residual sector, accommodating low income populations in the least desirable dwellings and locations.⁵ One well documented consequence is that the otherwise welcome demise of overinstitutionalisation—the undermining of a “control and containment” policy for dealing with disease—has contributed to an unprecedented increase in homelessness⁶ and to the changing health profile of homeless people.^{7,8} A second consequence has received much less attention.

As local authorities have responded to the housing implications of community care, the use and effectiveness of mainstream housing policy to meet general medical needs (mobilising the philosophy of housing as health promotion) has been eclipsed by the development of “special” housing initiatives, which are targeted towards the fairly narrow range of medical needs experienced by those “elderly,” “mentally handicapped,” “mentally ill” or “physically disabled” populations who had once been institutionalised. Even then, only a small proportion of these institutionally defined special populations can be accommodated,^{8,9}

and notwithstanding the benefits for some of these people, special housing initiatives can be criticised as both segregative and stigmatising.¹⁰ The “special needs” approach has, in short, begun to drift away from the ideal of housing as health promotion and towards the model of housing as containment and control it was designed to overcome.

It is in this context—at the height of the special needs era—that the AIDS and housing movement has gathered momentum. A national AIDS and housing project was set up in 1985 as a joint venture of the National Federation of Housing Associations and the Special Needs Advisory Service, with initial backing from a charitable trust, in response to the failure of housing institutions to provide adequate accommodation for people infected with HIV.^{11,12} Activists immediately faced the dilemma that, on the one hand, claims to special dispensation could reinforce the stigma already attached to AIDS, but that on the other hand, in a rapidly restructuring welfare state, special designation is the most effective way to secure housing resources on the grounds of medical need. The AIDS and housing movement chose, with others, to campaign to extend the scope of special designation beyond groups traditionally associated with the process of deinstitutionalisation to include others (black people, single homeless people, and one parent families as well as people with HIV) who also experience discrimination and disadvantage in the housing system. People infected with HIV therefore laid claim to special housing resources both on the grounds of medical need, and in the face of discrimination through mainstream housing policy.

Building on this claim, a range of AIDS and housing guidelines have now been developed: the Housing Corporation has issued circulars, some local authorities and London boroughs have drawn up policies, and working groups associated with charitable and voluntary organisations have published reports.^{11,13,14} Notwithstanding their origins in the special needs tradition, these recommendations promise to shift the balance of the special housing debate away from its implicit preoccupation with containment and control towards the more ambitious ideals of disease prevention and health promotion.

Firstly, the new guidelines identify a fixed address rather than a particular form of dwelling as the centrepiece of health care policy for patients positive for HIV. Research continues to expose the inadequacy of primary health care available to homeless people,¹⁵ and the problem is compounded for people with AIDS,^{16,17} who are particularly vulnerable to homelessness: young single people have low priority in most local authority waiting lists; and HIV infection is a barrier to obtaining a mortgage.¹⁸ The expansion of the private rented sector seems likely to occur up market; down market tenants face only the prospects of short

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leases and easier eviction for delayed payment of rent. In this context, the housing solution has to come from the public sector, whose most humane option may be to define applicants positive for HIV as "vulnerable" under the homeless clause of the Housing Act, thus giving them a statutory right to shelter.^{11,14}

Secondly, it is not simply shelter but permanent accommodation with security of tenure that is recognised as the centrepiece of care in, and by, the community for patients with AIDS. Currently, in both the market and state sectors of the housing system, people experiencing the symptoms of HIV are often forced to move, either to gain access to the caring services that are "packaged" into particular forms of accommodation (a problem addressed in the government's recent response¹⁹ to the Griffiths report) or because their incomes can no longer sustain mortgage repayments. Such moves may not only destroy crucial networks of informal care but may be stressful enough to cause the disease to progress.¹² The subsequent costs of hospitalisation and drugs may well outweigh those of more innovative housing solutions such as shared ownership schemes (incorporating patients' existing homes), in which local authorities might take a stake and perhaps develop some kind of leaseback arrangement.¹⁴

Finally, and crucially, new housing for health policies are required to acknowledge the heterogeneity of the population infected with HIV and to cater to the diversity of needs expressed within this group. As a self-conscious attempt to advance the interests of those disadvantaged or disabled by poor health, the AIDS and housing movement requires patients to have control over their living and health care environments. There is, then, no single special solution but rather a variety of options, from residential care (in which housing officers may play an important role²⁰), through dispersed hostels or core and cluster developments to different combinations of single or shared, supported or independent accommodation. The overriding principle has become known as "normalisation"^{20,21}—the reabsorption of essentially segregative special

initiatives into more integrative mainstream policies.

The AIDS and housing movement builds a bridge between the ideal of meeting medical needs through mainstream housing, health, and social services and the reality of a threadbare welfare net held together with a patchwork of special schemes. It exposes the increasingly fine line between housing interventions designed to prevent disease and promote public health and policies that aim to control, manage, and contain the problems of particular sick people. It could tip the balance of special provision from control and containment to disease prevention and health promotion—and the impact of this achievement for public health stretches well beyond the needs of people with AIDS or HIV infection.

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ANY QUESTIONS

A woman with a history of hay fever developed an acute urticarial reaction after eating shellfish. How common is this allergy and what treatment is advised?

The acute urticarial response is a mild form of the full anaphylactic response, causing laryngeal oedema, angio-oedema, bronchospasm, and circulatory collapse. Usually a self-limiting disorder, it is frequently initiated by a type I hypersensitivity reaction to food or drug administration. Degranulation of mast cells and basophils mediated by IgE with release of histamine and other short term vasoactive and bronchoactive mediators, such as prostaglandin D₂ and leucotriene C₄ (slow reacting substance of anaphylaxis), all play a part in the reaction.¹ Acute urticaria is common and has been reported to affect as many as 10-20% of the population at some time in their lives, but what proportion of these cases relate to allergy to shellfish is not known. As in the patient described, there is an association with atopy in roughly half the sufferers.^{2,3} The common ingested causes of this syndrome in addition to shellfish are eggs, peanuts, milk, nuts, soya, wheat, fish, and drugs. In many patients with urticaria or angio-oedema, however, no known cause can be identified.

The diagnosis is usually clear from the history or examination, or both, but identifying the cause can be much more difficult, particularly if it is not readily apparent from the history. Skin prick testing with extracts of foods under suspicion, and specific IgE (measured by radioallergosorbent test) or IgG, IgA, and IgM (enzyme linked immunosorbent assay) concentrations may help in diagnosis, but they are frequently negative, particularly in non-atopic patients. The best test remains the double blind placebo controlled food challenge. This is complex to perform but is useful in confirming and

refuting suspected causes for the allergy. It can also be useful as a battery test in those patients with recurrent severe lifethreatening anaphylaxis in whom no cause is otherwise apparent.

Acute attacks should be treated with intramuscular adrenaline 0.5 ml of one in 1000 repeated as necessary. Intravenous hydrocortisone (3 mg/kg) and antihistamine—for example, 10 mg chlorpheniramine—should also be given, followed by a short course of oral corticosteroids, such as prednisolone, and with one of the new selective H₁ receptor antagonists such as terfenadine or cetirizine. The only certain treatment is strict avoidance of food that is known to provoke allergy, and in this instance all shellfish should be avoided, as there is frequently cross reactivity between different crustacea.³ Avoidance should be life long, as few people seem to outgrow or become tolerant to their allergy.

If attacks have been life threatening patients should be provided with their own emergency treatment kit consisting of adrenaline (preferably autoinjectable), prednisolone, and an H₁ antagonist, with instructions on how to self-administer these in case of inadvertent ingestion. As the allergens from crustacea have not been well characterised desensitisation should not be undertaken. All patients with frequent or lifethreatening attacks should be referred to an allergy clinic for assessment.—S L JOHNSTON, *research fellow*, and S T HOLTGATE, *professor of immunopharmacology, Southampton*

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