Housing and Health

An introduction to housing and health

Stella Lowry

> The connection between health and the dwellings of the population is one of the most important that exists
> FLORENCE NIGHTINGALE

A recent WHO publication on housing and health mentioned the need to reduce the "cruel toll of death and disease directly attributable to the appalling living conditions of one quarter of the world's population."[1] We can all accept that living in shanty towns in the Third World can damage people's health, but many of us have forgotten how much housing can influence health in Britain.

Housing and public health

The Victorians appreciated the association between poor housing and ill health. They explained it in terms of the miasmic theory—bad smells transmitted disease—but their solutions (slum clearance and improved sanitation) did improve health. Improvements in the death rates from infectious diseases like cholera and typhoid and, to some extent, tuberculosis owed more to improved standards of housing than to knowledge of microbiology and the development of antibiotics.[2]

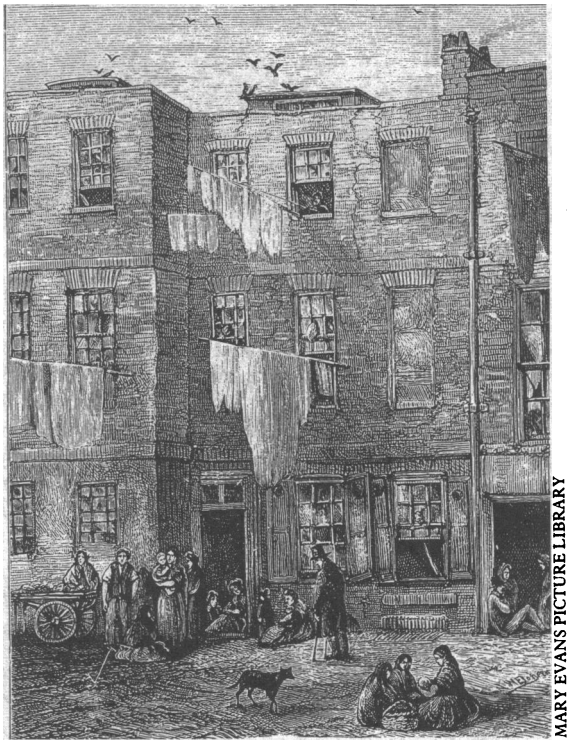
The Victorians took a broad view of health. Their attempts to reduce overcrowding in slums were prompted largely by outrage at the potential harm to mental and moral "health" of inadequate separation of the sexes, but the results reduced the spread of infectious illness. Housing had a central role in the development of the public health movement.[3,4]

In 1918 there was an outcry when it was discovered that 41% of conscripts were of medical grade C3—unfit for military service. There were calls for improved public health, including better housing. After the war houses were in short supply—600 000 too few by the armistice, and over 800 000 by 1921—and a huge building programme began. The solid, well constructed semidetached houses with private gardens and indoor bathrooms built in the 1920s and 1930s really were the promised "homes fit for heroes." Indeed, they still compare favourably with many of the houses built since.

Never mind the quality

As the slums were cleared, partly for rebuilding and partly through bombing during the second world war, the emphasis shifted from quality to quantity. The trend reached its peak in the 1960s, when vast rapid build projects sprang up. Builders were given financial incentives to use new, and largely untested, building techniques; and thousands of people were housed in the preformed concrete blocks that resulted.

A period of relative complacency followed. The housing crisis seemed to be over. The baby boom had finished, and housing no longer topped the political agenda. Then the complaints began. The new houses were not structurally sound. They were hard to heat, prone to damp, and filled with asbestos. There was nowhere for children to play, rubbish accumulated in walkways, and graffiti flourished on walls. Despite such visible deterioration people were slow to look for effects of modern housing on health.



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Overcrowded Victorian slums had obvious effects on health

Doctors and housing

Housing still influences our health. Houses should provide basic health requirements like shelter, warmth, sanitation, and privacy, and badly designed or dangerously constructed houses can directly damage residents' health. Doctors need to know to what extent their patients' illnesses are the result of their living conditions, and whether anything can be done to improve them.

Hospital doctors are increasingly expected to use day case techniques and early discharge. General practitioners are being asked to manage more and more conditions largely or solely in the community. These trends can be followed safely only if the home conditions of each patient are well known and the likely effects of these are understood.

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PHOTO COOP

Emphasis on quantity rather than quality

People with health problems (such as the elderly, the handicapped, and the chronically sick) may have specific housing needs. Doctors are often asked to help patients obtain rehousing on medical grounds, and they need to understand how this system works if they are to make the best use of it.

Perhaps the most important reason why doctors should know about housing is that they are in a position to influence change. A BMA book on deprivation and ill health summed up that responsibility: "Doctors are responsible for promoting health as well as treating illness, and doctors share with other disciplines a responsibility to suggest social policies which might prevent avoidable illness."[5]

Blame the victim

There has been a change of emphasis in public health in the 1970s and 1980s. Health issues have become individualised—people should stop smoking, eat less fat, use condoms, not share needles, have regular cervical smears. Even the campaigns to prevent hypothermia have degenerated into an obsession with individual behaviour: stay in one warm room, wear several layers of clothes, and knit yourself a woolly hat.

Of course people should know how their behaviour affects their health, but we have become so obsessed with individual responsibility that we have stopped looking at how more widespread intervention might help. Perhaps with a prime minister who claims that "there is no such thing as society" this is not too surprising. As Cathy McCormack of the Easthall Residents Association in Glasgow puts it, "Blame the victim syndrome is the worst disease we know."

But things are changing. Architects and planners now accept that many of the problems of concrete slab blocks are caused by genuine faults in the design. A vast number of people live in homes that are well nigh impossible to keep warm and dry, and the effects on their health are slowly being recognised. Many old properties are in desperate need of maintenance work. Increasing numbers of people are visibly homeless. The complacency of the seventies and early eighties is fading, and housing is emerging as a major public health issue again.

Science and common sense

It is difficult to study the effects of housing on health. Common sense tells us that the relation exists, but it is usually impossible to prove it scientifically. Doctors who have come to expect p values and confidence intervals will be dismayed at the lack of hard science. The mass of confounding variables in each situation makes assessment of any one risk factor almost impossible. This lack of a firm association provides a useful loophole for governments that cannot or will not fund the remedial programmes needed.

In this series of articles I will look at some of the more important influences on housing and health in Britain today. I will try to identify how much has been established by scientific investigation and how much by sensible observation, and will discuss to what extent we should insist on hard evidence before demanding change. I hope that this series will provide an introduction to the subject for young doctors who, like me, trained in the years of relative complacency and that it will also provide a useful update for those who have always appreciated the association between housing and health.

1 World Health Organisation. *Housing and health. An agenda for action.* Geneva: WHO, 1987.
2 Cartwright FF. *A social history of medicine.* London: Longman, 1977.
3 Jacobs M, Stevenson G. Health and housing: a historical examination of alternative perspectives. *Int J Health Services* 1981;1:105-22.
4 Ormandy D. Historical development of housing hygiene policy. *J R Soc Health* 1987;107:39-42.
5 British Medical Association, Board of Science and Education. *Deprivation and ill health.* London: BMA, 1987.

ANY QUESTIONS

What treatment is advised for acne in a pregnant woman?

The effect of pregnancy on acne is varied. Some patients improve, others worsen, and in some patients there is no change whatsoever. I advise anyone who takes oral treatment for acne to discontinue the treatment in pregnancy. It is recommended by the makers of retinoic acid, topical tetracycline, and clindamycin that such preparations should not be used. Topical preparations that can be used are benzoyl peroxide and erythromycin. All treatments should be applied not just to the spots but to the whole of the affected area twice daily. This may control the acne well.

Occasionally I am asked to treat a pregnant woman who has acne. Such a patient should be given erythromycin 500 mg twice daily (preferably after the third month of pregnancy), and this treatment can be continued until term. The tablets are best taken 30 minutes before food to maximise absorption and should be combined with a topical treatment, either benzoyl peroxide or erythromycin. There will be little improvement in the first month of treatment, but in two months there will be a 40% improvement and in six months 80%.

One drug that is totally contraindicated in pregnancy is isotretinoin. This is a drug that may be used only in hospital and is reserved for patients with severe acne. Patients who take such treatment should not become pregnant and should use adequate contraception.—W J CUNLIFFE, *director, Leeds Foundation for Dermatological Research*

Cunliffe WJ. *Acne.* London: Dunitz, 1989.