MEDICAL PRACTICE

Contemporary Themes

Housing, health, and illness

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Summary and conclusions

Cases referred to a community physician in his role as medical adviser to a housing authority were reviewed. A new system of classifying health problems was devised because conventional diagnostic classification was found to be inappropriate. The effectiveness of medical intervention was apparently low, since only 29 out of 612 (4·7%) applications for rehousing on medical grounds were successful. The effectiveness of the community physician's role was limited by the available resources and the number of cases he could take before the housing committee.

It is proposed that the use of medical resources for intervention in such cases is acceptably efficient, though this proposal is based on value judgement rather than on economic grounds. Doctors should be concerned in improving housing conditions, which are still unacceptably poor in many parts of Britain, in the interests of improving general standards of public health.

Introduction

The World Health Organisation's definition of health suggests that anyone who lives in bad housing conditions is ipso facto in a state of bad health. If doctors deal with health problems then every housing problem is appropriate for their attention. If, however, the role of the doctor is to deal only with "disease or infirmity" he should support only those patients in whom a relation between bad housing and disease or infirmity can be established; but the nature of this relation is difficult to determine.

In the city of Oxford a person waiting to be rehoused who claims to have relevant medical problems is given a form by the housing department to be completed by himself, his general practitioner, and his health visitor. It has been my practice not to visit the patients referred to me. Not only would visits consume more time than I can allocate to housing matters, but I do not think that I can assess the effect of the housing conditions on the applicant in a single interview. The applicant's distress may also be increased both consciously and unconsciously because he knows that his chance of rehousing depends on the way he presents his problems. In Oxford many people believe the myths that having another baby or "telling the health visitor that you feel like battering the baby" increase their chances of being rehoused by the council.

From 1 April 1976 to 31 March 1977 612 people claimed medical priority for rehousing. As I could not find any firm evidence linking conventional diagnoses to people's housing conditions I developed a new system of classifying health problems in housing applicants (see table).

New classification of health problems

Surprisingly, there were no cases in class I (see table), even though sound research on groups of people has shown that housing conditions influence health. The associations between an unsatisfactory physical environment and respiratory problems[1-3] and between housing conditions and mental wellbeing[4] have been studied, but an association is much less easy to prove in an individual case. The relation between unsatisfactory housing and asthma is particularly difficult to determine. Damp houses and a humid environment provide favourable conditions for house dust mites[5,6] but families living in damp conditions often have emotional problems capable of triggering asthmatic attacks. Many mothers believe that dampness causes colds and "chest problems" in children even if they are not asthmatic. This worry might precipitate asthma in a child who was otherwise predisposed to asthma, especially since the child is often taken to the housing

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New system of classifying health problems of housing applicants in Oxford 1976-7, number of applicants claiming medical priority for rehousing, and number of successful applications

Problems attributable to housing conditions	Class	No of applicants	No approved by housing committee
Definitely causing physical disease	I	0	0
Possibly causing physical disease	II	76	0
Possibly causing mental disease	III	138	12
Physical disease or infirmity makes previously satisfactory housing unsuitable*	IV	111	9
Effects of disease make conditions difficult†	V	65	8
No disease or infirmity but conditions affect social wellbeing	VI	222	0

*For example, when someone living in a second-floor flat has a stroke.
†For example, when someone with a colostomy shares bathroom and toilet with eight others in multi-occupied house, or when a handicapped child is cared for in unsatisfactory conditions.

department or the general practitioner's surgery as "proof" of the effect of a cold, damp house. Because there were always other factors I could not state that housing conditions and disease were definitely related in any case in which the applicant claimed that physical illness was due to the housing conditions, and I included all such cases in class II.

Moreover, the decision to classify a problem as "mental illness" (class III) rather than a "social problem" (class VI) was often artificial because it often depended on whether the applicant initially chose to go to the social services department or to the general practitioner. Nevertheless, the social services department may also present cases to the housing committee, so people do not have to become patients to receive priority.

Action taken

If there was no relation between housing and ill health (class VI) the applicant was given no points, but all other cases received five points. Some community physicians grade medical need, and award a different number of points for different diagnoses or degrees of infirmity. I do not think that such comparisons can be made—for example, bronchitis cannot be compared with arthritis, or asthma with depression or any other condition. The distress caused to the person and to his or her family is more important than the diagnosis. Since I cannot quantify distress with the time at my disposal I allocated the same number of points to everyone. Applicants receive points for overcrowding and lack of amenities, and often accumulate 30 or more points a year. The medical contribution to their points total is thus relatively small, and had little effect on the time they spent waiting to be rehoused. I presented 20 of the 612 cases to be considered for immediate rehousing by the housing committee.

Effectiveness of medical intervention

Because medical problems contribute little to the points total the community physician can intervene effectively only by using his powers to take cases to committee. The effectiveness of rehousing someone in a wheelchair who lives in an upstairs flat (class IV), or the family of a severely handicapped child living in a house without a toilet or hot water (class V) is self-evident. The most difficult cases to assess were those in which housing conditions were said to be causing mental illness (class III). The 12 households in class III whose applications had been granted priority by the housing committee were followed up after they had been rehoused. Ten of the 12 had improved six months after being rehoused. In five cases the general practitioner had been able to reduce the amount of psychotropic drugs prescribed, though three were still receiving the same amount. The remaining two had not been receiving any medication while living in unsatisfactory housing conditions. Two showed no sign of improvement. One of them, a single woman aged 74, was depressed and anxious after two burglaries and threatening telephone calls. Being rehoused in a sheltered flat had made no difference to her symptoms after six months, but she had previously had psychiatric treatment for depression. In the other case, a married couple with an infant were rehoused and were initially pleased with their flat, but difficulties in paying heating bills and complaints by neighbours about the baby's crying led to a recurrence of the wife's depression.

Medical intervention could be more effective if more people were granted priority for rehousing on medical grounds. Some councillors, however, are unwilling to see their points system bypassed by too many medical cases, for they think that this would reduce the credibility of the points scheme in the public's eye and encourage more people to seek, maintain, and magnify ill health in the hope of being rehoused. But when the effectiveness of intervention is assessed it should be remembered that the whole community benefits as well as those few individuals who are helped. Close contact with housing applicants and their problems allows health service staff, especially occupational therapists, to establish links with other council departments such as the housing, planning, architect's, and environmental health departments, and to influence the design and planning of dwellings and modify the points scheme. The community physician also helps many through his links with local authority departments, the opportunity he has to work with central government departments, and his continuing contact with individuals and their families, who are anxious and often angry.

Efficiency

The cost amounts to about 30 minutes of a community physician's day and two hours' secretarial help. To this must be added the cost of the general practitioner's and health visitor's contribution. This cannot be estimated, but the cost to each practice is probably fairly small. The total cost has to be set against the effectiveness of the results. Although the use of resources is apparently inefficient, I find that I must be concerned with many cases to achieve even a few successes. My credibility with the councillors rests largely on their knowledge that I have been concerned with many such cases. If, for example, I bring a case to committee in which a depressed mother is thought to be at "breaking point" each councillor can easily recall 10 or more families who have been in a similar position. The councillors' knowledge that I have more than 100 similar cases on my files and have discussed many of them with the social services department is important when they weigh up my evidence in bringing cases to the committee "on medical grounds."

Conclusion

Although the effects of bad housing and the effectiveness of medical intervention cannot be adequately quantified, unsuitable housing conditions clearly affect the quality of family life and child development. The housing conditions of too many people in Britain, which is still a prosperous country, are unacceptably poor. They are a major public health problem—for health, in the WHO definition, is "not merely the absence of disease or infirmity." Not only should doctors support people who live in bad housing conditions in their quest for better housing, as they do at present, but the medical profession should also make its voice clearly heard in a call for satisfactory housing to improve the public health.

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References

[1] Holland, W W, *et al*, *British Medical Journal*, 1969, **2**, 205.
[2] Colley, J R T, and Reid, D D, *British Medical Journal*, 1970, **2**, 213.
[3] Yarnell, J W G, and St Leger, A S, *British Journal of Preventive and Social Medicine*, 1977, **31**, 183.
[4] Moore, N C, *Public Health*, 1975, **89**, 109.
[5] Lopez, L, Wessels, F, and Salvaggio, J E, in *Bronchial Asthma*, ed B Weiss and M S Seigal, p 303. Boston, Little, Brown, 1976
[6] Frankland, A W, in *Bronchial Asthma*, ed B Weiss and M S Seigal, p 557. Boston, Little, Brown, 1976.

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