

Off the Radar

Housing disrepair & health
impact in later life



Author: Sue Adams

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www.careandrepair-england.org.uk
info@careandrepair-england.org.uk

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Any views expressed in this publication are not necessarily those of the BRE who have solely provided national data concerning housing tenure, incidence of housing hazards, age, health and disability profile of heads of households and drawn on the work of the BRE Trust project 'The costs of poor housing to the NHS'.

Overview

Decent suitable housing underpins health and wellbeing, particularly in later life. Older people are more likely to live with chronic health conditions which can be exacerbated by poor housing and most also spend a greater amount of time at home.

With significant funding constraints in local authorities, especially for adult social care, and in the context of growing pressures on the NHS, sustaining good health in later life is more important than ever.

This report sets out the national picture with regard to the scale of poor housing conditions amongst older people, the resulting impact on the health and wellbeing of an ageing population, and the concentration of poor housing in the owner occupied sector.

It quantifies the scale of action necessary to address housing disrepair amongst older households, identifying the benefits of targeted use of public funds for those in greatest need.

“ *The distribution of health and well-being needs to be understood in relation to a range of factors that interact in complex ways. These factors include whether you live in a decent house.* ”

Sir Michael Marmot (2010) *Fair Society, Healthy Lives: The Marmot strategic review of health inequalities in England post-2010. The Marmot Review*

Contents

Summary	5
Chapter 1 Older Households: Age, housing, tenure, disrepair and poor health	6
Ageing, housing and tenure	6
Older age and poor housing	7
• Falls risk	
• Cold	
• Serious disrepair	
Ageing, ill health and disability	9
Older age, low income and poverty	9
Chapter 2 The health costs: Ageing, ill health and poor housing	10
The cost benefits of reducing health risk through improved housing	12
Chapter 3 Housing disrepair in later life – the human stories	13
Chapter 4 Addressing housing disrepair: Rationale & past success	18
Reducing private sector disrepair	18
• Minor Works, Major Step	
The wider fiscal benefits of home ownership	19
Chapter 5 Looking forward: Integration agenda and cost effective solutions	21
Integration of health, social care and housing	21
• Moving to a better home – a minority option	
Looking forward	22
Value for Money Action	23
Appendix 1 References	24
Appendix 2 Table	25

Summary

One of the major social achievements of the last century is the significant increase in life expectancy. Improved housing has been an important contributor to that gain as decent, suitable housing is a key determinant of the health and wellbeing of a population, particularly in later life.

In the latter part of the twentieth century there was a radical shift from renting to home ownership, particularly amongst lower income groups. Today 76% of older people (55 years or more) are owner occupiers and 96% live in mainstream housing.

When population ageing and low income home ownership combine there are wider social consequences, particularly for the NHS, as lower income older home owners find themselves struggling to meet the costs of home repairs and maintenance.

- Some 1.2 million (21% or one in five) of households aged 65 years or over lived in a home that failed to meet the Decent Homes standard in 2012.
- The vast majority (79%) of households aged 65 years or over living in a non-decent home were owner occupiers (934,000).
- The main reason for homes failing the Decent Homes standard is the presence of a Category 1 hazard. The two commonest Category 1 hazards are falls risk and excess cold.
- 731,000 households aged 65 years or over lived in a home with a Category 1 hazard, 85% (619,000) in owner occupied homes.
- The majority (78%) of older people with long term illness or disability living in a non-decent home are owner occupiers.

This concentration of poor housing in the private sector is of key importance when planning preventative housing measures eg. to reduce health risks, prevent falls and support safe, timely hospital discharge, all of which impact on NHS costs.

The estimated costs of poor housing to the NHS is £1.4 billion pa. The cost to the NHS, in first year treatment costs, of the poorest housing among older households (55yrs+) is c. £624 million.

Housing, its availability, standard and suitability, has a critical role to play in plans for a more integrated approach to provision of health services and social care. Housing disrepair;

- impacts on mental as well as physical health,
- affects carers' ability to care,
- can fundamentally undermine older people's ability to live independently, safely and as part of the wider community.

Housing is a key part of a nation's infrastructure, impacting upon economic activity, childhood and educational attainment, and health across the life course. In England there has been a long history of systematic action to improve and maintain housing stock condition.

There are significant potential economic and social gains from a coherent national response to addressing private sector housing disrepair, including employment opportunities, economic stimulus through enabling best use of assets, as well as health gains.

As well as addressing housing supply, existing housing stock disrepair needs once again to be 'on the radar' of policy makers across housing, health and social care.

CHAPTER 1

Older Households: Age, housing, tenure, disrepair and poor health

One of the major social achievements of the last century is the significant increase in life expectancy, doubling from 40 in the 1880s to over 80 today. Many would claim that an important contributor to that change has been improved housing conditions.

In the latter part of the twentieth century there was a radical shift from renting to home ownership, particularly amongst lower income groups. This was driven to a significant degree by government policies, such as the Right to Buy programme, as well as the opening up of access to mortgages for middle & lower income groups

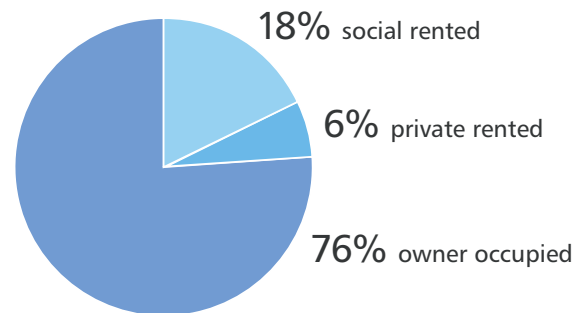
- In 1918 the majority (77%) of households rented (76% private rental), with the remaining (23%) in ownership¹
- In 1970 half of the population (all ages) were home owners – this peaked at 70% in 2002¹
- Today 76 % of older householders (55yrs+) are owner occupiers

However, when population ageing and low income home ownership combine, particularly in an age of austerity, there are wider consequences, particularly for the NHS, as lower income older home owners find themselves struggling to meet the costs of home repairs and maintenance.

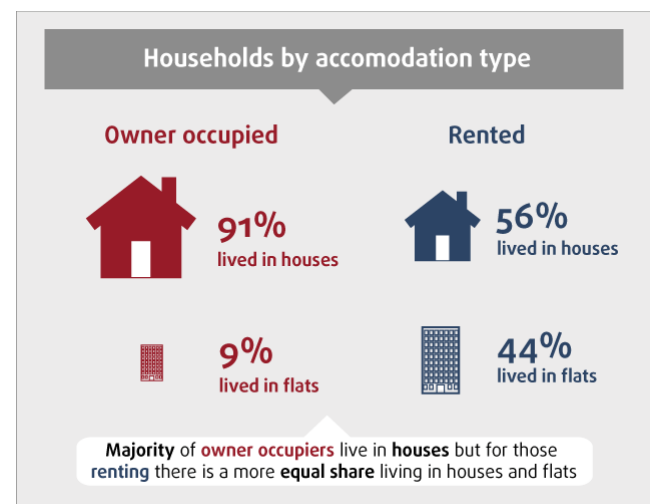
Ageing, housing and tenure

Most older people (55+) are owner occupiers.

In 2012, England comprised of around 21.9 million households. Of these approximately 9.5 million (43%) were aged 55 years or over, 5.6 million (25%) were aged 65 years or over and 2.5 million (12%) were aged 75 years or over.



The type of home that renters and owners [all ages] live in is very different. The majority (91%) of owner occupied households live in houses compared with 9% in flats. For renters it is a fairly even spread of 56% in houses and 44% in flats.¹



Unless otherwise indicated the following analysis of the housing situation of older people is based on the English Housing Survey (EHS) 10/11 & 11/12 data analysed by BRE for PHE Homes & Ageing report and for C&RE. Age of household refers to the age of the household reference person. All data refers to England only.

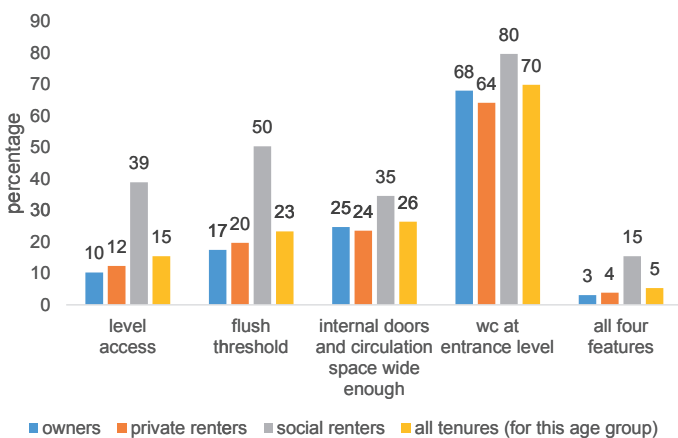
¹ England & Wales, Census data, ONS

The design characteristics of the current housing stock mean that the vast majority is poorly designed for an ageing population.

95% of all homes do not include the most basic of characteristics that make homes accessible ie level access, ground floor WC etc.

Furthermore, of even this small minority of properties, just 5% with accessibility features, the majority are in the social rented sector. Hence there are limited options for moving within the owner occupied sector to a ready-made accessible home – most would need to be adapted.

Proportion of each accessibility feature among households aged 65 years or more, by tenure, 2012.



Only a minority (4%) of older people (55yrs or more) live in housing that has been specially built for older people (including sheltered housing, retirement housing, extra care) ie. 96% live in mainstream housing.

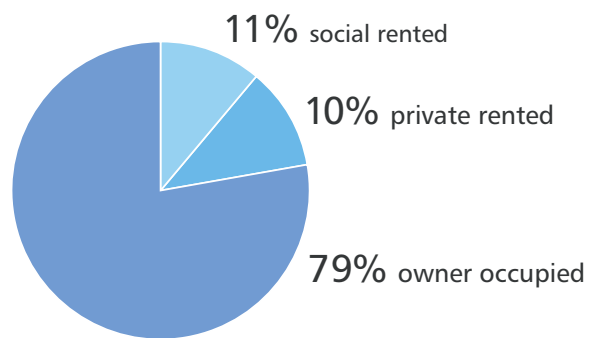
Based on a range of national data sources² for England and Wales, and their comprehensive national data collection about the availability of specialist housing for older people, Elderly Accommodation Counsel estimate that a third of renters (primarily social renters) over retirement age live in specialist housing compared with just below 5% of home owners.

Older age and poor housing

The Decent Homes standard is a nationally defined standard³ which is measured by indicators that include need for urgent repairs, age of the kitchen and bathroom facilities and thermal comfort, as well as presence of a 'Category 1 hazard'. This is a hazard that presents a significant risk to the health of the occupant.

Some 1.2 million (21% or one in five) of households aged 65 years or over lived in a home that failed to meet the Decent Homes standard in 2012.

The vast majority (79%) of households aged 65 years or over living in a non-decent home are owner occupiers (934,000).



165,000 vulnerable* householders aged 75 or more lived in a non-decent homes (19% of vulnerable households in this age group).

73% vulnerable* older householders (60 years or more) who resided in non-decent homes lived in private sector housing (over 310,000 of the 430,000).

*note that vulnerable in the context of the SEH is defined in terms of receipt of specific welfare benefits.

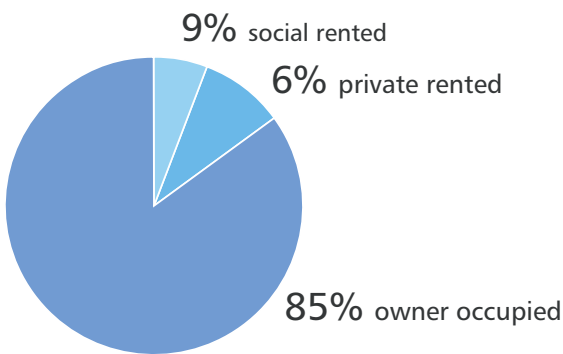
The main reason for homes failing the Decent Homes standard is the presence of a Category 1 hazard. The two commonest Cat1 hazards are falls risk (on stairs/on/between levels/bathing) and excess cold [see Appendix 2 Table 1].

In 2012, around 731,000 households aged 65 years or over (13% of this age group) lived in a home with a Cat1 hazard.

The most common Cat1 hazards for this age group were those associated with the risk of falls (368,000) followed by risk of harm due to excess cold (325,000).

Of the 731,000 Cat1 hazards among households aged 65 years or over, 85% (619,000) were located in owner occupied homes ie. this tenure is overrepresented among homes with poor housing. Around 69,000 (9%) Cat1 hazards were in homes occupied by private renters and the remaining 43,000 (6%) were homes occupied by social renters.

Category 1 hazards (falls and excess cold) by tenure for households aged 65yrs or over, 2012



Falls Risk

One of the major causes of death, injury and decline amongst older people are falls in the home.⁴

The annual cost for hip fractures alone (UK figure from NHS Choices website) including medical and social care, is about £2 billion. Disrepair and the incidence of falls hazards in the homes of older people are clearly a public health issue.

There is a well evidenced link between housing conditions and falling⁵ and also analysis of how poor or unsuitable housing conditions increases the risk of falls.⁶

Total number of Cat1 hazards associated with falls risk for households of 55yrs and over is 794,689.

The most common Cat1 hazards for those aged 65yrs and over were those associated with the risk of falls (368,000). Risk of falls on stairs were the most common (230,000) followed by falls on level, falls between levels, then falls associated with bathing.

Whilst incidences (and seriousness of health/care consequences) of falls increase with age, in terms of the prevention agenda and 'upstream interventions' removal of Cat1 falls hazards for all 'younger old' age groups would be beneficial.

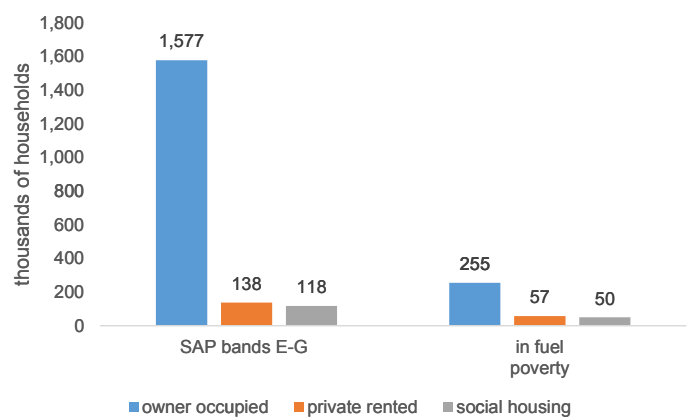
Cold homes

Cold homes exacerbate a range of health problems eg. COPD, arthritis etc and increase risk of an acute episode eg stroke, heart attack.

The number of Cat1 hazard risk of harm due to excess cold for those of 65yrs and over is 325,000 (for all of those 55yrs and over this more than doubles to 689,666)

The majority of older people living in a home which has a Cat1 excess cold hazard are owner occupiers.

Living in a cold home by tenure - households aged 65 yrs or over, 2012



⁴ WHO, ⁵ Heywood et al (2007), ⁶ University of Warwick (2003)

Serious disrepair

The majority of the worst housing is in the private sector.

There were 636,000 householders of 60yrs or more living in homes in serious disrepair.

90% of these lived in private sector housing (569,000).

Ageing, ill health and disability

Ill health and disability in later life brings challenges with day to day living for many.

52% of people 65 and over reported having a long term health problem or disability that limits activities of daily living.⁷ For example, 47% of women & 39% of men over 65yrs reported difficulty walking even a moderate distance.⁸

Of the 9.5 million households aged 55 years or over, 3.8 million (40%) were households including a person with a long term health condition or disability.

Older age, low income and poverty

Older people are not universally well off.

Between 2010 and 2013, 4 in 10 pensioners experienced 'persistent poverty' ONS (2015).

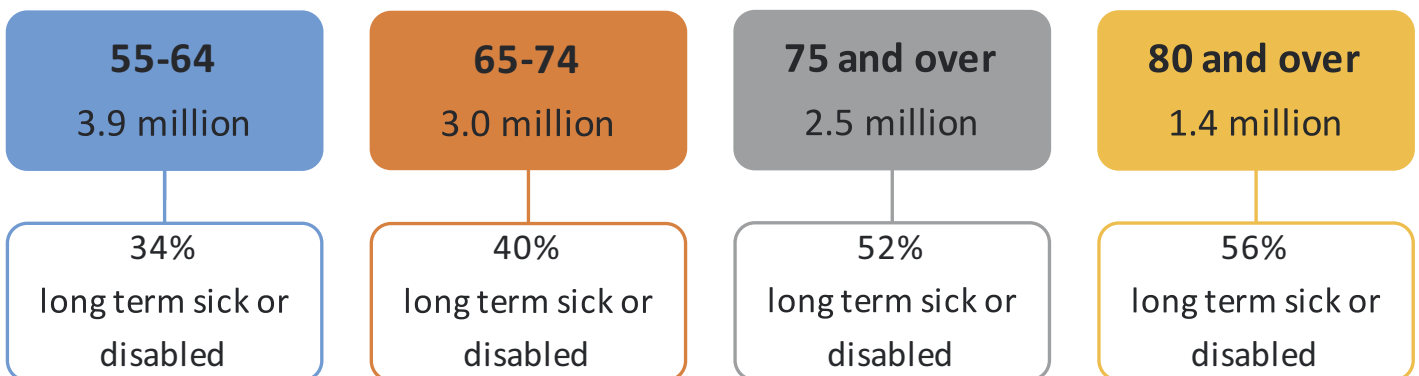
Whilst pensioner poverty has fallen significantly over the past decade, over a million pensioners remain living on the edge of poverty.

Neither does home ownership indicate wealth. 67% of pensioners in poverty are owner-occupiers.

Whilst the risk of poverty is lower among owner-occupiers (14%) compared to renters (22%), there are more owner-occupying pensioners and therefore 67% of pensioners in poverty are owner-occupiers (1.1m people). The risk of poverty is also higher for single women pensioners (21%) and non-white British pensioners (26%), and is very slightly higher for pensioners aged over 75 (18%).

Source: Pannell J et al (2012) Market Assessment of Housing Options for Older People

Age of household and long term illness



⁷ ONS 2, ⁸ Melzer (2012)

CHAPTER 2

The health costs: Ageing, ill health, disability and poor housing

The estimated costs of poor housing to the NHS is £1.4 billion* per annum⁹

The cost to the NHS, in first year treatment costs, of the poorest housing among older households (55yrs+) is estimated at £624 million*.

The vast majority of older people with a long term illness or disability who are living in a non-decent home are owner occupiers.

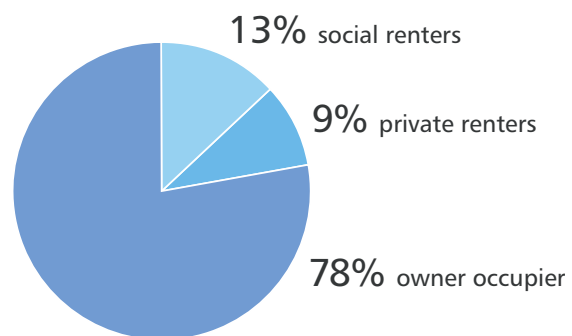
This tenure concentration is of key importance in considering the preventative housing measures that can be taken to reduce health risk and hence costs.

Ageing, ill health and poor housing

Older people are the primary users of health services, with an estimated 40% of the NHS budget spent on caring for people of 65 yrs and over.¹⁰

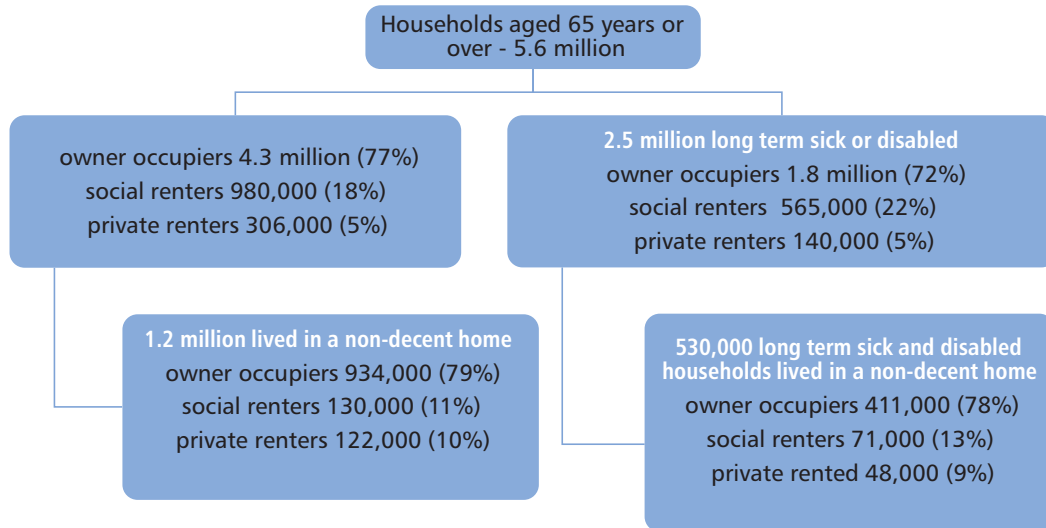
Many of the common chronic health conditions experienced by older people have a causal link to, and/or are exacerbated by particular housing conditions. These include heart disease, stroke, respiratory conditions, mental health, arthritis and rheumatism.¹¹

Of the 2.5 million households aged 65 years or over with a long term illness or disability, around 530,000 (21% of this group) lived in a non-decent home, the vast majority (78%) in owner occupied homes.

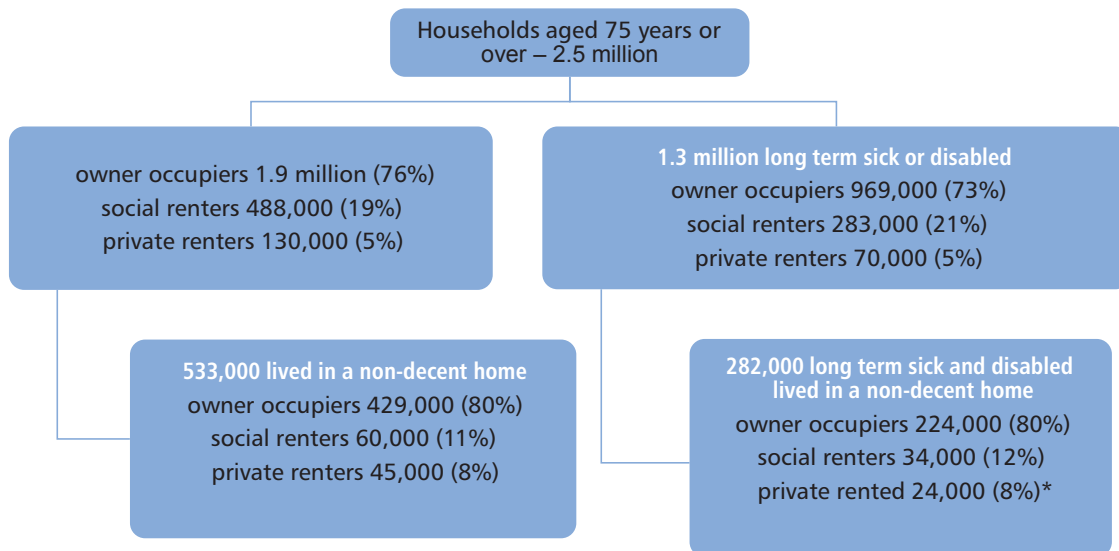


*These amounts are based on conservative modelling by BRE using NHS data and HHSRS data from the EHS [Roys et al, Nicol et al 2010].

Characteristics of households over 65 years of age by long term illness, non-decent homes and tenure, 2012



Characteristics of households over 75 years of age by long term illness, non-decent homes and tenure, 2012



The cost benefits of reducing health risk through improved housing

The potential cost savings to the NHS that would arise from removal of each individual type of Cat1 hazard for households over 55yrs is set out in detail in Appendix 2; Table 1.

The highest value of cost savings if all hazards of that category were removed is excess cold. However, the cost of the remedial works to reduce excess cold is significantly higher than the works needed to address falls risk. Bathing adaptations have the lowest payback period.

The analysis in Table 1 of cost benefits is based on the data & modelling underpinning the BRE report *'The cost of poor housing to the NHS'*.

It is important to note that this report also states that it is not just the worst housing that impacts on people's health.

Whilst the study defines poor housing as that having at least one Category 1 hazard (scoring over 1,000 on the HHSRS scale), it comments there are also many homes that score between 500 and 999 on the HHSRS scale (Category 2 hazards) which require improvement, and that all well planned home improvement schemes will improve health and wellbeing, even in a small way, and this will have a cumulative effect in saving NHS costs over time.

As the cases described in Chapter 3 illustrate, housing disrepair:

- impacts on mental as well as physical health,
- affects carers' ability to care,
- can fundamentally undermine older people's ability to live independently, safely and as part of the wider community.

There are therefore wider consequences resulting from poor housing conditions for social services as well as for the NHS, but to date these have not been quantified to the same extent as health impact.

“ ... some of the most significant public health gains can be achieved by focusing on the most cost-effective improvements to the poorest housing, usually occupied by the most vulnerable people. ”

Graham Jukes OBE CFCIEH, [former] CEO of Chartered Institute of Environmental Health in foreword to the BRE report *The cost of poor housing to the NHS (2015)*

CHAPTER 3

Housing disrepair in later life – the human stories

Health risk: Lack of heating and hot water

Mr Knight is 83 years of age and lives with his wife who cares for him full time in the small, modest home which they own. Mr Knight has a heart condition and asbestosis affecting his breathing and mobility. He needs to keep warm as the cold exacerbates both of these conditions. Mrs Knight suffers from arthritis and is recovering from breast cancer. They live on a basic pension and their savings ran out some years ago.

Mr and Mrs Knight contacted West of England Care & Repair (WECR) when their central heating boiler had broken down and was beyond repair. They had no heating and insufficient funds to pay the £1,700 needed for a new one. Charitable funding applications were made and finally the funding was secured through contributions from Foundations Independent Living Trust, WECR Repair Hardship Funds and the Avon and Somerset Police Benevolent Fund.

During the time when they had no central heating Mr and Mrs Knight's electric shower 'exploded' and the cables burnt out. Due to another medical condition Mr Knight needed a daily hot shower. WECR raised more charitable funds, including a contribution from the WECR Hardship Fund, arranged for an electrician to visit and install a new shower and upgrade the existing electrics (it turned out that there was no earth and the wiring did not meet current regulations).

With a new boiler now installed and work to the shower the Knights finally have the necessary heating and hot water which are so critical to their health and ability to live safely at home.



Health risk: Falls & wellbeing

Mrs Hindley, in her 80s, lives in her own home. She was referred to the WECR by a council occupational therapist because of a health problem that was causing frequent bouts of dizziness, loss of balance and hence falls. Mrs Hindley's terraced home has steep steps front and back and these posed particular risks.

Because of the location the house is a listed building and so there are strict controls on any alterations. WECR came up with an acceptable design of handrails and secured the necessary permissions from the council. A grant was obtained to pay for the front door steps rail but Mrs Hindley was very keen to be able to go out into the garden, and so paid for the back door steps rail from her limited savings. WECR organised and supervised the work which was done by a trustworthy contractor at the agreed price.

Mrs Hindley is very happy with the result. She can now leave the house safely to attend hospital appointments. She has been a keen gardener all of her life and the back door steps rail installation means that she can continue to spend time enjoying her garden safely, which has had a very positive impact on her general health and wellbeing.



Health risk: Falling ceiling and gas disconnection

Mr Monk is 67 yrs old and now lives alone in what has always been his family home. For some years he cared for his father who has now been admitted to a nursing home. Mr Monk has breathing problems and a crumbling spine, meaning his mobility is limited. He recently had a hospital stay with a broken vertebra. His conditions make him particularly vulnerable to the cold.

Mr Monk contacted WECR when part of his kitchen ceiling had collapsed. When the caseworker visited the house was very cold and damp. She discovered that the heating boiler and cooker had been condemned. When the gas company had visited the home to install a smart meter they had cut off the gas completely as they said it was dangerous.

Mr Monk lives on a low income and only had a small amount of savings which would not cover the full cost of a replacement boiler. The caseworker raised contributions from charitable funds alongside a small amount from the WECR hardship fund and they were able to install the boiler before the cold weather set in.

Again, through charitable funds the caseworker also organised the ceiling repair and replacement cooker and put in an application for Attendance Allowance. This was awarded at the lower rate, which means that Mr Monk is now able to pay for carers to come in and give him some much needed additional support.

The house is now much warmer, and this has helped to reduce the damp. Mr Monk is really grateful for this – he goes out infrequently so it's really important that his home is warm and safe.



Health risk: Damp and worry

Ms Amber is 62 and is disabled due to severe arthritis. She owns her small, low value home in Warrington. She lives on a low income and has spent much of her life caring for her [now adult] son who had a brain injury. A flat roof on the house was leaking and Ms Amber had no money for the repair even though the resulting damp was aggravating her arthritis as well as causing worry and distress.

Warrington home improvement agency (WHiA) secured quotes from trusted contractors and made an application made for a Safe and Secure* small grant. These essential repairs were carried out rapidly for just over £2,000 leaving Ms Amber healthier and better able to carry on living independently and continuing to support her son.

*Safe & Secure is a council grant for urgent repair works to remove a Category 1 from the homes of low income home owners ie where health is being put at risk by that disrepair.



Health risk: Stopping the decline

Mr and Mrs Bolter are in their 70s. They live on a low income in their own low equity home. They had a leaking roof with water coming through the ceiling and couldn't get a commercial loan to meet the repair costs. This was causing them great worry and not helping their health conditions – both had arthritis and mobility difficulties.

They contacted WHiA who were able to help them to secure a loan through their local social lending scheme, Home Cash Plan*. When the Bolters came into the WHiA office they had a look at a the demonstration shower room. They had both been struggling to use the bath and so putting in a shower would be a great help in enabling them to live independently and reduce risk eg of a fall. They decided to take out a loan to cover both the roof repair and the shower installation.

WHiA also organised the building work, obtaining competitive prices and ensuring high quality jobs were completed. This has left the Bolters living safely and well at home, better able to maintain their independence and with reduced health risk.

*Home Cash Plan offers a lifetime no service loan. Borrowers do not need to make regular payments unless they choose to. The loan (with accumulated interest) is repayable when the property is no longer the borrowers main home and it is sold.



CHAPTER 4

Addressing housing disrepair: Rationale & past success

Decent, suitable housing is a key determinant of the health and wellbeing of a population.

Housing is a key part of a nation's infrastructure, impacting upon economic activity, childhood & educational attainment, plus health across the life course. Housing underpins the very fabric of society.

As well as action to increase housing supply, in England there has been a long history of systematic action to address housing stock condition.

This has ranged from early slum clearances to area regeneration, to targeted grants for low income householders and latterly the Decent Homes programme, which brought most of the social housing stock up to a decent standard.

Reducing private sector housing disrepair¹²

Major housing clearance and rebuilding programmes took place primarily during the 1930s, after WW2 and continuing up until the late 1970s.

Action by national government played the major role in tackling poor housing conditions throughout the twentieth century.

The main focus, particularly post Second World War, was on area based demolition and clearance, with small payments to the owners of demolished properties and predominantly a move of those households into social rented housing.

From the 1980s private sector housing renewal policies gradually moved away from clearance towards renovation of existing properties with the state either directly intervening, such as through block renovation, or incentivising householders to make improvements to individual properties through grant aid based on an assessment solely of the property, and then after the 1989 Local Government and Housing Act [the 1989 Act], through means tested mandatory grants.

Peak grant aid for individual home renovation coincided with a major shift into owner occupation by low income households, stimulated to a significant degree by the Right to Buy initiative and a government vision for a shift to home ownership for the majority.

The new grant regime marked a significant departure from arrangements over the previous twenty years. Under the 1989 Act housing renovation grant assistance was targeted at the worst condition properties, using a revised standard of fitness for human habitation, and aimed at people on low incomes, through introduction of a means test and grants that covered up to 100% of essential renovations.

Minor Works, Major Step

The new grant system also included introduction of Minor Works Assistance for small-scale works [grants of up to £1,000 per application, max. £3,000 over three years]. These grants paid for essential small repairs and improvements to the homes of people aged 60 or more, for thermal insulation, properties within a clearance area or proposed clearance area, and minor adaptations for the benefit of someone of 60yrs or more. Applicants for minor works assistance had to be in receipt of at least one means tested benefit.

The changes to the government's approach to addressing private sector disrepair brought about through the 1989 Act resulted in significant improvements in the housing conditions of older people living in poor private housing. This was greatly assisted by the spread of home improvement agencies, local schemes which assisted low income older people to apply for grants, organise and carry out the essential repairs, improvements and adaptations.

In 1992 a review of the impact of 1989 Act changes to private sector renewal concluded that despite some shortcomings (particularly the lack of an upper grant limit) the new grant regime was very effective at targeting resources on the worst housing conditions, reaching the poorest households and most vulnerable groups. In 1990 there were 90,000 renovation grants awarded and an estimated 30,000 minor works grants.

¹² Adams et al (2010)

Significant changes were made to national legislation determining private sector housing grants and programmes to address disrepair in 1996 (including introduction of a grant limit of £20,000 and abolition of mandatory grants) and then in 2002 (Regulatory Reform Order (Housing Assistance) which gave local authorities even greater levels of discretion with regard to addressing disrepair.

Expenditure on private sector disrepair continued to decline after 1996. The specific national budget to address private sector disrepair was cut entirely in 2011-12.

Wider fiscal benefits of home ownership

The shift of lower income households out of renting and into home ownership has resulted in significant fiscal gains to government.

The greatest level of identifiable savings are to housing benefit.

Modelling by the Strategic Society looking at the longer term fiscal impact of the rapid decline of home ownership amongst younger people estimates that by 2060 the UK Exchequer would have to spend an extra £8.13 billion on Housing Benefit for pensioners each year compared to 2012.¹³

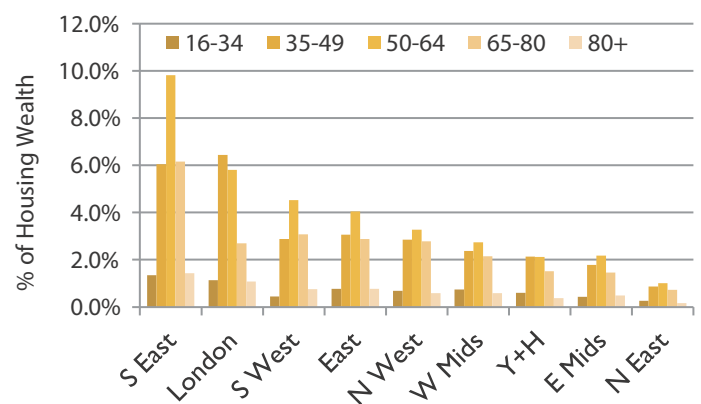
Mr & Mrs Jones bought their small house under the Right to Buy scheme when in their mid 50s, spending all of their savings on the purchase and some refurbishment. They subsequently retired and live on basic state pension. Their income level means that they would have been entitled to 100% housing benefit had they remained as tenants. Assuming they live in the home for 20 years after retirement, and taking a very simplistic rent estimate of £80 per week, this is a saving of £83,200 in 'unpaid' housing benefit.

There are further significant gains to the state arising from transaction income when homes are bought and sold [stamp duty, inheritance tax].

There are considerable economic gains arising from the purchasing power of home owners eg. spending on the home environment (maintenance, improvements, modifications as well as general decorating, furnishings etc) are higher when people own their home.

There are also wider fiscal benefits arising from acquisition of an asset, the proceeds of which are increasingly likely to be used to meet later life care costs [noting that the very uneven geographical distribution of housing equity/wide differential increase in value means that this wealth gain has been unevenly distributed with a large north/south divide and over all housing wealth concentrated in London and South East].

Housing wealth distribution: England (2011)



Source: Searle B. (2013) *Who owns all the housing wealth? Patterns of inequality in England Briefings No 03 University of St Andrews.*

Other social gains from home ownership include higher levels of satisfaction with home and neighbourhood (UKHLS), security and stability with solid social networks, all of which contribute significantly to wider health, wellbeing and quality of life in later life and hence impact on health and social care costs.

Whilst it is important to note that many of the above features (solid social networks, satisfaction with home) are also found in good social housing neighbourhoods, reducing security of tenure and resulting in increased instability of neighbourhoods will potentially reduce this incidence and home ownership may become the only secure tenure, with consequential impacts on health and wellbeing.

¹³ Lloyd

One of the disadvantages of low income home ownership in later life, particularly for those in lower value property, is the additional housing costs that arise but which are not taken account of in current means tested benefits systems.

Housing costs for low income tenants living on means tested benefits are separately addressed through payment of housing benefit assistance for rent.

There is no comparable assistance for housing costs for home owners living on means tested benefits except for some currently limited assistance with the interest payable on a mortgage or in some cases for loans taken out to pay for essential repairs. Thus the cost of routine repairs, maintenance, insurance etc have to be met from income levels which do not accommodate such expenditure. Even this limited assistance looks set to be withdrawn under current proposals for welfare reform.

This 'uneven playing field' for low income home owners was part of the rationale for past schemes of assistance for low income, older owner occupiers, such as the Minor Works grants. It provided, an element of redressing that imbalance, as well as preventing both property deterioration (with resulting impact on a neighbourhood) and also negative health impacts of housing disrepair in individuals.



“ *Rising house prices and declining rates of home-ownership among the young have led some to argue that policymakers should now focus on improving the private rented sector.*

However, this debate ignores the public spending implications of declining rates of home-ownership, particularly related to the cost of Housing Benefit for future pensioners.

James Lloyd, The Strategic Society

CHAPTER 5

Looking forward: Integration agenda and cost effective solutions

Housing, its availability, standard and suitability, has a critical role to play in the current plans for a more integrated approach to provision of health services and social care.

The rise in low income home ownership, particularly amongst older people, and the drive to encourage a new generation of home owners also requires a policy response to enabling people to stay on, as well as getting onto, the property ladder. This is of particular importance with regard to wider public health.

Decent, suitable housing is an essential element of overall national infrastructure. There are potential economic and social gains from a coherent national response to addressing private sector housing disrepair, including employment opportunities, economic stimulus through enabling best use of assets and health gains.

Integration of health, social care and housing

Following the introduction of the Care Act 2014 steps are being taken to drive forward a vision of integrated health and social care.

Housing has been identified as potentially playing an important role in effective integration.

The Care Act Guidance (15.53) states:

Housing plays a critical role in enabling people to live independently and in helping carers to support others more effectively. Poor or inappropriate housing can put the health and wellbeing of people at risk, where as a suitable home can reduce the needs for care and support and contribute to preventing or delaying the development of such needs.

Health and social care policies over recent years have quite rightly emphasised supporting older people to live independently in a home of their own, rather than

moving to expensive institutional care. This objective also reflects the wishes and aspirations of the majority of people in later life.

What is needed now is concerted, targeted action to ensure that the private homes in which older people live, particularly those on low incomes with chronic health conditions and disabilities, are made fit for purpose. Without such action, there will be growing demands on the NHS, particularly hospitals, as it becomes increasingly difficult to discharge patients to cold, unsafe homes.

As the cases described in this report (Chapter 3) illustrate:

- where there are good local housing solutions like those demonstrated in the examples, there are huge benefits to individuals and potentially financial gains for the NHS and social care.
- failure to make the connection between health, social care and housing disrepair is not only costly, but also has potentially dire consequences for individual older people, their carers and families.

Moving to a better home – a minority option

One of the responses to the problem of housing disrepair and the requirement for home adaptation amongst older people has been to propose moving home as ‘the’ solution.

Whilst for some people this is both their preference and a realistic option, for many it is neither desirable nor feasible, particularly for those in lower equity properties. As noted in Chapter 2, most older people (96%) live in mainstream housing and there is only a very small supply of specialist housing (c 500,000 units) with three quarters of this in the social rented sector.¹⁴

Within the mainstream stock, only 5% of homes have even the most basic accessibility features, with the majority of this stock again in the social rented sector, and hence the majority of private properties will require adaptation. For those in the lowest equity properties and at the bottom of the local housing ladder, moving to a better home in later life is not a realistic solution to living with housing disrepair.

¹⁴ Pannel et al

Looking forward

The Better Care Fund, a move to joint commissioning, the prevention agenda and relocation of Public Health in local authorities all provide potential structures and frameworks for joint action to address housing disrepair amongst older owner occupiers. However, in most places the 'here and now' pressures of financing existing systems appears to be leaving little capacity to step back and take a fresh approach that includes housing within a longer term vision of prevention.

There have been a few beacons of related innovative action, particularly with regard to home adaptations and involvement of housing services in hospital discharge, which C&RE has documented [see careandrepair-england.org.uk/home-from-hospital-initiatives].

However, there are currently significant inefficiencies and something of a 'sticking plaster' approach to tackling urgent disrepair, with front line providers such as home improvement agencies searching for multiple small grants from charities and hardship funds to raise even a few hundred pounds to remedy defects that can make or break hospital discharge, for example.

At a time of major funding constraints and reductions in many areas of government expenditure, it becomes ever more critical to seek out system inefficiencies and to target earlier interventions, particularly in the health sector.

A new wave of fast track 'safe and warm' home interventions would reap benefits in the short, medium and longer term.

It is timely to put addressing housing disrepair back on the radar of public policy, particularly with regard to health and care in the context of an ageing population.



“ *Good housing is essential to health and wellbeing... The recent changes to the health system, with local authorities now responsible for public health and with the establishment of Local Health and Wellbeing Boards, provide a great opportunity to build more integrated approaches to improvements in prevention and reductions in need for costly health care* ”

Professor Kevin Fenton, National Director of Health and Wellbeing at Public Health England, in foreword to *'Homes and ageing in England'* (2015)

Value for Money Action

- A targeted programme of 'repairs and adaptations on prescription' linked to fast track hospital/health related interventions, home improvement agencies and low cost handyperson services would contribute to addressing delayed transfers of care and enable preventative measures to be put into place which reduce calls on the health service.
- The public health responsibilities of local authorities should specifically include addressing housing related health issues arising from housing disrepair across all tenures.
- Pioneering new solutions are needed from social lenders (eg. major building societies) to help to address more significant levels of disrepair. In order to reach the most disadvantaged this needs to be developed alongside a linked change to the welfare benefits system for low income owner occupiers eg support with mortgage interest payments.
- Impartial information and advice about housing and care enables older people with limited resources to make best use of their savings and housing equity. A national roll out is needed of the well evidenced¹⁵, cost effective mix of national website & helpline (via EAC FirstStop) operating alongside local partners, particularly home improvement agencies which offer fast repairs and adaptations help and assistance with moving.
- Tackling housing disrepair at scale eg. systematically addressing specific Cat1 health hazards (eg falls, cold homes) would be a highly beneficial large scale infrastructure programme, creating employment in the building industry, particularly small and medium sized builders, and again, delivering on a wider public health agenda.

¹⁵ Cooper (2015)

APPENDIX 1

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APPENDIX 2

Table 1

The cost and benefits to the NHS, of reducing HHSRS Category 1 hazards to an acceptable level for households aged 55 or more

Hazard	Number of Category 1 Hazards	Average repair cost per dwelling	Total cost to repair	Savings to the NHS per annum if hazard fixed	Payback (years)
Excess cold	689,666	£4,344	£2,995,907,903	£441,564,353	6.78
Falls on stairs	467,776	£989	£462,535,027	£71,609,794	6.46
Falls on the level	197,177	£792	£156,129,838	£34,700,172	4.50
Falls between levels	93,723	£1,134	£106,290,746	£17,519,361	6.07
Fire	33,325	£4,115	£137,132,934	£12,725,126	10.78
Collision and entrapment	27,664	£592	£16,369,553	£5,898,263	2.78
Falls - baths	36,013	£486	£17,487,933	£7,254,790	2.41
Dampness	11,385	£7,523	£85,653,060	£3,325,961	25.75
Hot surfaces	55,985	£1,871	£104,731,366	£7,868,316	13.31
Lead	41,927	£1,677	£70,306,239	£5,194,893	13.53
Entry by intruders	11,576	£1,180	£13,665,167	£3,226,578	4.24
Radon	63,518	£1,127	£71,568,454	£5,329,649	13.43
Sanitation (Personal hygiene)	20,138	£1,119	£22,539,641	£2,336,281	9.65
Food safety	15,373	£961	£14,781,003	£1,782,264	8.29
Pests (Domestic hygiene)	13,442	£709	£9,531,479	£1,612,639	5.91
Overcrowding	509	£16,748	£8,524,561	£48,943	174.17
Noise	1,230	£1,137	£1,398,960	£349,771	4.00
Carbon monoxide	3,751	£508	£1,907,042	£364,193	5.24
Structural collapse	1,169	£288	£336,667	£100,569	3.35
Electrical problems	2,692	£2,111	£5,681,466	£360,016	15.78
Ergonomics	3,288	£470	£1,544,131	£395,108	3.91
Un-combusted fuel gas	2,246	£523	£1,175,477	£212,525	5.53
Lighting	0	£0	£0	£0	0.00
Water supply	0	£0	£0	£0	0.00
Excess heat	0	£0	£0	£0	0.00
Explosions	0	£0	£0	£0	0.00
All dwellings with a Category 1 hazard	1,431,482	£2,990	£4,279,628,929	£623,779,566	6.86

Note: The total number of dwellings with a Category 1 hazard is different to that provided in the 'Poor housing as assessed by the HHSRS' section. The above cost of poor housing model uses EHS 2010+2011 data.



For further information contact

Care & Repair England
The Renewal Trust Business Centre
3 Hawksworth Street
Nottingham NG3 2EG

Tel: 0115 950 6500
email: info@careandrepair-england.org.uk
website: www.careandrepair-england.org.uk

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