



HOPE VI:
*Where Do We Go
from Here?*

Poor Health: Adding Insult to Injury for HOPE VI Families

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and Elizabeth Guernsey

Poor health is an even bigger problem for HOPE VI families than lack of employment.

Congress created the HOPE VI program in 1992 to address the myriad problems in distressed, urban public housing developments: deteriorating physical conditions; rampant drug dealing and violent crime; and a resident population with high rates of unemployment, welfare receipt, and teen pregnancy, and low levels of education and literacy (see text box on page 9). HOPE VI, now up for reauthorization, differed from earlier attempts to improve conditions in federally subsidized public housing because it explicitly included a focus on resident well-being rather than simply focusing on improving buildings. Specifically, the program sought to help residents achieve self-sufficiency—that is, to become employed and leave the welfare rolls. To help achieve this goal and provide support to residents during the revitalization process, HOPE VI mandated that sites use a portion of their grants to provide residents with what they called “community supportive services.” Although there was no official requirement for what these services should consist of, generally, housing authorities chose to focus their efforts on employment- and education-related programs (Popkin et al. 2004).

But concentrating service resources on employment-related programs assumes that residents actually are able to work, particularly at the kinds of physically demanding jobs available to low-skilled workers, such as nursing assistants, housekeepers, and restaurant servers. Further, it assumes that not having a job and being

self-supporting is the biggest challenge facing residents. But findings from the HOPE VI Panel Study suggest that poor health is an even more serious problem for these families than lack of employment.

Because of well-documented links between physical environment and resident well-being, the HOPE VI Panel Study has focused intensively on residents’ physical and mental health since it began in 2001.¹ As a result, the study has become the most comprehensive source of information on public housing residents’ health available. The HOPE VI Panel Study tracks a sample of 887 residents from five distressed public housing developments that were slated for redevelopment in 1999 and 2000 (see text box on page 9). We surveyed residents before relocation in 2001, and again in 2003 and 2005. In each round of surveys, we asked respondents a series of questions about their overall health status and about specific medical conditions.

At baseline, HOPE VI Panel Study respondents were in far worse health than other low-income households, reporting high rates of poor health overall, as well as high rates of asthma and depression (Popkin et al. 2002). Because of the dramatic nature of these findings, we added a longer battery of questions to the 2003 follow-up to enable us to understand more about the dimensions of the health problems facing HOPE VI residents. The 2003 survey results highlighted the vulnerability of this population: a quarter of the young working-age

adults (age 18–44) reported their health as fair or poor, with more than 57 percent of adults between age 45 and 64 reporting the same; respondents reported much higher rates of such conditions as diabetes, obesity, and depression than black women nationally (Harris and Kaye 2004). Further, respondents in poor health were less likely to be employed (Levy and Kaye 2004).

At the second follow-up in 2005, we added items on specific conditions including arthritis and stroke, as well as questions intended to assess how much these conditions impeded residents' ability to carry out their daily activities. In this brief, we use the information from the 2005 follow-up to update and expand our understanding of the dimensions of the health challenges facing HOPE VI families. The findings from the 2005 survey and our analysis of how respondents' health has changed over time present a picture of a population in shockingly poor health, a situation that seems to be worsening rapidly over time as residents grow older. Our findings suggest that the health situation of HOPE VI families is a problem so severe that it calls for urgent attention and new approaches to providing effective services to this extremely vulnerable population.

Respondents Are in Extremely Poor Health Overall

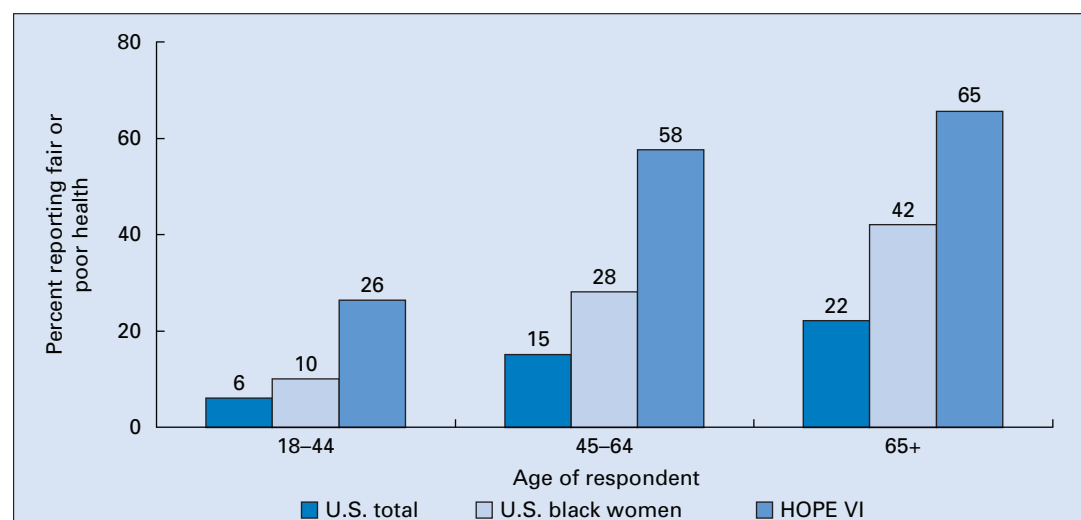
HOPE VI Panel Study respondents have reported extremely poor health since the

baseline survey in 2001 (Popkin et al. 2002). In 2005, two out of every five respondents (41 percent) identified their health condition as either "fair" or "poor." Further, as figure 1 shows, at every age level, HOPE VI Panel Study respondents are much more likely to describe their health as fair or poor than other adults overall and even than black women, a group with higher-than-average rates of poor health.² In 2005, HOPE VI respondents age 18–44 were almost three times as likely as black women nationally to report fair or poor health; those age 45–64 were twice as likely; and those over age 65 were more than 20 percentage points more likely. These negative self-reported health ratings are an important public health concern because they are predictive of morbidity—that is, serious illness—and mortality (Bosworth et al. 1999; Franks, Gold, and Fiscella 2003). Thus, these ratings indicate a population at high risk for serious health problems.

Further, respondents' health has not improved over time, even though most are no longer living in the distressed environments associated with negative health outcomes. At the second follow-up in 2005, nearly all the respondents (84 percent) had been relocated, with only a small number still living in their original developments in two sites (Shore Park/Shore Terrace in Atlantic City and Ida B. Wells in Chicago). As of 2005, 43 percent of relocates were living in the private market with

The health of HOPE VI families is so poor that it calls for urgent attention.

FIGURE 1. Self-Reported Health Status of HOPE VI Respondents, 2005



Sources: 2005 HOPE VI Panel Study and National Health Interview Survey.

vouchers, 5 percent had moved to revitalized HOPE VI sites, 13 percent were unassisted rent-ers or homeowners, and 22 percent had moved to other traditional public housing.³ Respondents who had relocated to the private market with vouchers or other assistance were living in significantly better housing in neighborhoods that were dramatically safer. In contrast, those who remained in their original units or had moved to another traditional public housing development did not experience these improvements in their circumstances (Buron, Levy, and Gallagher 2007; Comey 2007; Popkin and Cove 2007).

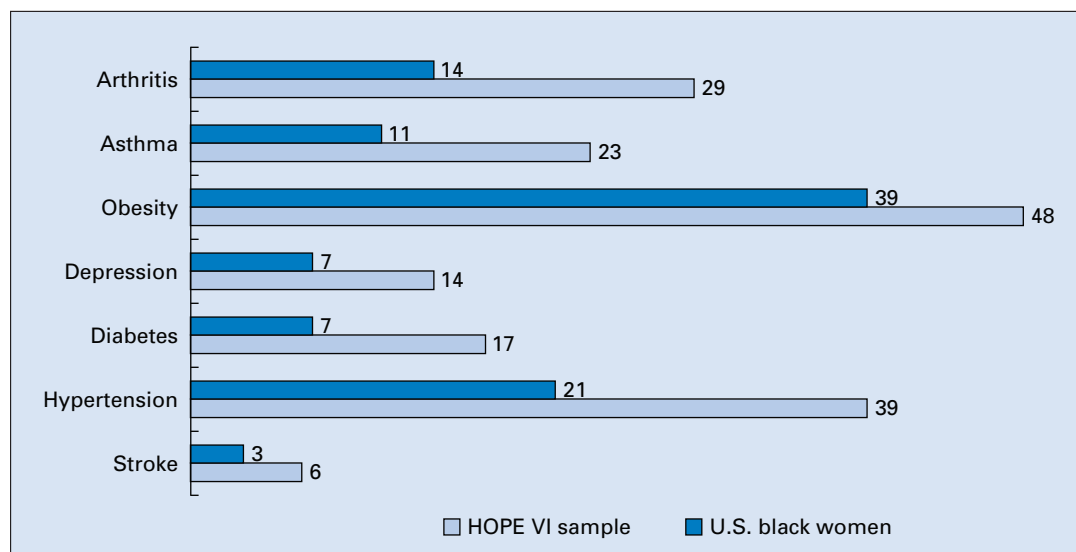
But, while private-market movers have experienced a striking improvement in living conditions, we find no evidence that these changes have affected their health. Across the sites, 76 percent of respondents either reported no change or a negative change in their health status between 2003 and 2005. There was no evidence that the type of housing they were living in affected their self-reported health ratings—private-market renters were as likely to report poor health as those living in traditional public housing. Respondents' health might already have been so poor by the time they relocated that even a dramatic improvement in their living environment may not have been sufficient to produce detectable improvements.⁴

HOPE VI Adults Suffer from High Rates of Chronic Illness

As noted above, overall health ratings are important because they indicate a high risk of serious medical conditions. In 2005, as in the earlier follow-up, we asked respondents whether they had been diagnosed with a range of specific medical conditions. Our results show that these problems persist, and, for several measures, have grown worse over time. Figure 2 shows the proportion of HOPE VI Panel Study respondents reporting seven major medical conditions (arthritis, asthma, obesity, depression, diabetes, hypertension, and stroke), and compares them with a national sample of black women, a group that already has higher prevalence rates for many health problems than whites and men.⁵ For every condition except obesity, the proportion of HOPE VI Panel Study respondents reporting being diagnosed is twice or more that of the comparison group; for obesity, the difference is still large—about 10 percentage points. Mental health is a very serious problem—not only depression, but also reported rates of anxiety and other indicators are very high: overall, 29 percent of HOPE VI respondents indicated poor mental health.⁶

In addition to having much higher than average rates of serious health conditions overall, a significant number of HOPE VI Panel Study respondents face the

FIGURE 2. *Presence of Chronic Illness among HOPE VI Respondents and Black Women Nationwide, 2005 (percent)*



Sources: 2005 HOPE VI Panel Study and National Health Interview Survey.

burden of multiple serious health problems. As in 2003, we looked at the number of individuals suffering from arthritis, asthma, diabetes, hypertension, or obesity. Across the sample, nearly three-quarters of respondents reported that their doctor had told them that they had at least one of these conditions, almost half reported two or more of these five conditions, and nearly a quarter reported having three or more (figure 3). Unlike the overall health ratings, the proportion of respondents reporting multiple problems did not change from 2003 to 2005.

Another sign of deteriorating health status is the significant increase in the number of respondents who indicated that their health condition needed regular, ongoing care. A total of 45 percent of respondents in 2005 reported a need for ongoing care, up from 40 percent in 2003 and 36 percent in 2001. Further, 22 percent of the respondents who said they did not need ongoing care in 2003 reported needing such care in 2005.

Finally, not only do HOPE VI Panel Study respondents report high rates of disease, they are also clearly very debilitated by their illnesses. Of the respondents that were unemployed, 48 percent reported having a disability that prevented them from accepting any kind of work in the near future. For people who were employed at the time of the survey, 6 percent reported that their disability had made it difficult to keep a job in the past six months. One-quarter of the respondents reported having such difficulty with physical mobility that they could not walk three

city blocks, climb 10 steps without resting, or stand on their feet for two hours.

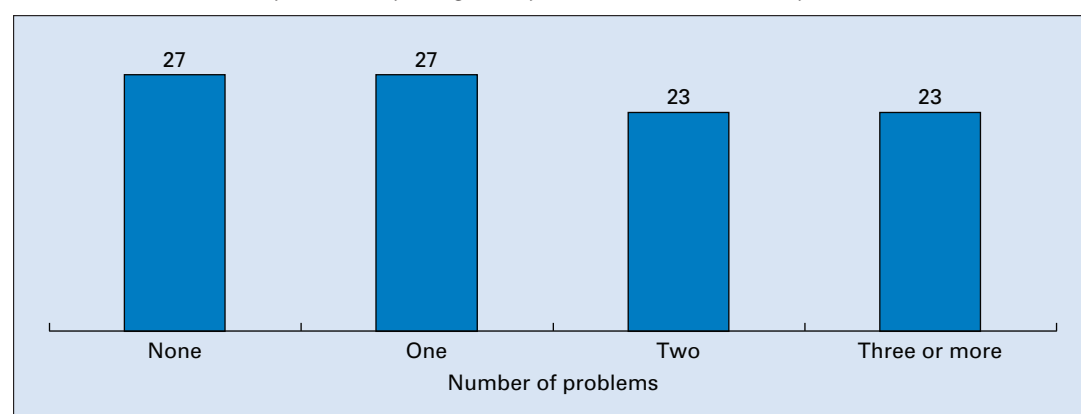
Death Rates Far Exceed National Averages

We tracked mortality rates for the HOPE VI Panel Study over the course of the study. The comparison of death rates between individuals in HOPE VI Panel Study and other vulnerable populations highlights the extreme vulnerability of the population. As figure 4 shows, for three different age categories, the death rate of HOPE VI residents exceeds the national average for black women—which is already high relative to other races (Murray et al. 2006)—with the gap increasing dramatically at older ages. The highest mortality occurred in D.C.’s East Capitol Dwellings, which had a large number of older residents, but the pattern was the same across all five sites.

To put our findings on mortality in context, we compared our results to those from another study of public housing residents from high-poverty communities, the Moving to Opportunity (MTO) demonstration (Orr et al. 2003). The MTO in-place control group—public housing residents who applied for a voucher but did not get one—is the best comparison group (although not perfect) for the HOPE VI Panel Study. The residents in the MTO in-place control group stayed in their original public housing development, which is likely the situation that HOPE VI Panel Study respondents would have been in had their development not been slated for revitaliza-

HOPE VI residents are significantly debilitated by their illnesses.

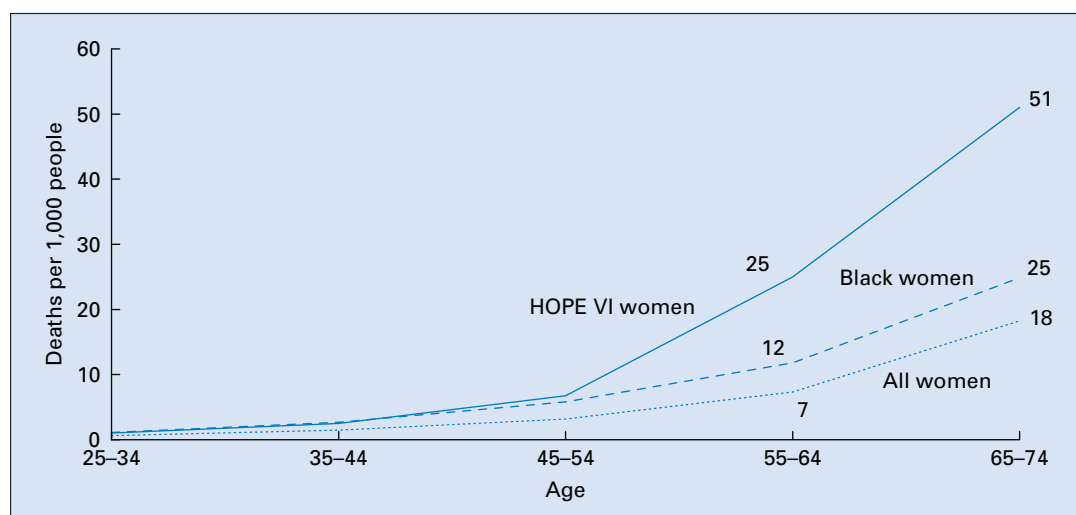
FIGURE 3. HOPE VI Respondents Reporting Multiple Health Problems, 2005 (percent)



Source: 2005 HOPE VI Panel Study.

Note: Health problems are one or more of the following: arthritis, asthma, diabetes, hypertension, and obesity.

FIGURE 4. Mortality Rates for HOPE VI Respondents versus National Samples, 2005



Sources: 2005 HOPE VI Panel Study and National Health Interview Survey.

tion.⁷ Surprisingly, given that the populations are relatively similar, mortality rates for the MTO control group are substantially lower than they are for HOPE VI Panel Study respondents, and little different than those for black women nationally.

Although the comparison to MTO raises questions, we cannot determine whether the high mortality rate for HOPE VI Panel Study respondents is, in fact, attributable to the effects of involuntary relocation. Without a true comparison group, we do not have hard evidence about what might have happened to these residents in the absence of HOPE VI revitalization. What we do know is that among the residents who died, the overwhelming majority reported fair or poor health at baseline (79 percent). Likewise, 83 percent of the deceased reported having an illness or needing chronic care at baseline. These residents were already frail, and the stress of living in distressed public housing may have contributed to their distress and increased their vulnerability. The high death rate, particularly among older respondents, underscores the need for intensive medical services and supports for public housing residents facing involuntary displacement. It may also justify a more detailed case-by-case analysis to reconstruct the deceased movers' stories in an effort to better understand what went wrong.⁸

Policy Implications

The HOPE VI Panel Study paints a portrait of a population experiencing serious physi-

cal and emotional distress. There is reason to be concerned that the multiple hazards of living in distressed public housing are interacting in ways that make matters worse. Like other poor urban residents, public housing residents have a very high likelihood of exposure to environmental factors that could negatively affect their health. However, unlike other poor residents of these same communities, public housing residents are more likely to stay in place and endure a broad range of social problems along with any environmental health risks to retain their subsidy.

Unfortunately, the health of America's public housing residents has received very little attention from policymakers over the years. This lack of information has very real consequences. For example, since the advent of Temporary Assistance to Needy Families, policymakers have reviewed various proposals linking the receipt for housing assistance to employment. The U.S. Department of Housing and Urban Development (HUD) now permits some housing authorities to require work as a condition of receiving housing assistance. In a similar vein, the Millennium Housing Commission report of 2002 recommended that, over time, the housing assistance system require residents who are not elderly or disabled to work as a condition of receiving aid. The Commission's report, however, makes no mention of the services and supports necessary to achieve this goal. While few would argue that self-sufficiency among public housing residents is an undesirable goal, failure to

recognize important variables, including whether health and physical limitations may stand in the way of work for a sizable portion of the public housing population, will likely result in remedies that create more problems than they resolve.

These findings have several important implications for policy.

Provide more support to vulnerable residents during relocation. The worsening health and high mortality rates for the HOPE VI Panel Study respondents imply an urgent need for better and more comprehensive support for families as they undergo the stress of involuntary relocation. Effective case management is particularly important for older and more vulnerable residents, who are particularly likely to suffer serious consequences (Smith and Ferryman 2005). Housing authorities should coordinate with health providers, provide support throughout the relocation process, and follow up for at least 12 months after the move. Further, they should plan their redevelopment processes carefully so that moving is not rushed and the most vulnerable residents do not have to move more than once.

Consider alternative definitions of self-sufficiency. Because of health problems, holding a job may be an unrealistic goal for many residents of distressed public housing. It may make more sense to set alternative standards for these residents, instead focusing on helping them manage their health conditions effectively—for example, get to appointments, obtain and use medications correctly, and take steps to improve diet and exercise. HOPE VI community supportive services could be required to include health and coordination with health agencies in their service packages. If followed, this strategy could have significant benefits for residents' lives—even maybe helping them become well enough to become employed. And, if residents are healthier and relying less on emergency rooms and hospitals, this strategy could mean significant cost savings for the public sector.

Broaden interventions to account for multiple risk factors. Planners of health interventions and researchers should consider developing interventions that address a broader range of health risks for public housing residents. Given the multiple risks public housing residents face in their homes and their neighborhoods, it is

very possible that their health problems might interact, resulting in even greater challenges to residents. For example, children suffering from asthma due in part to physical contaminants in the home may be more vulnerable to serious asthmatic attacks because they also endure stress due to violence and crime in their neighborhoods. Where possible, public health interventions serving public housing residents should address multiple risk factors rather than developing narrow clinical interventions that address a single health concern in isolation.

Improve information about the health status of public housing residents. The lack of information on the basic health conditions of public housing residents is a real barrier for health service program planning for this unique population. For public housing residents, who have a high likelihood of enduring poor living conditions within their home (Popkin et al. 2002; Comey 2004, 2007) and may also live in distressed and violent neighborhoods (Popkin et al. 2000; Buron 2004; Popkin and Cove 2007), there are serious questions about whether this vulnerable population may face even greater health risks than other low-income households with greater mobility and housing choice options. With elevated risks both inside and outside the home, there is reason to believe that financial relief provided by a public housing subsidy might also carry the hidden cost of serious health problems for residents. This situation would have tremendous implications for public housing services and program planning and would clearly have an impact on a resident's ability to graduate from publicly subsidized housing to self-sufficiency. As such, it is important to gain a better understanding of the health issues faced by residents of public housing and how they might be addressed via housing policies, targeted health interventions, or other means.

Strengthen ties between public and nonprofit agencies for improved health services to public housing residents.

Local partnerships highlighted by Health and Public Housing Conferences sponsored by HUD, the Joint Center for Political and Economic Studies, and the Urban Institute illustrate ways in which even limited cooperation between public housing authorities and public health agencies can improve the living environ-

ment and health of public housing residents. One example of an effective partnership comes from Providence, Rhode Island, where the Rhode Island Health Department and the Providence Housing Authority are now sharing address-level data to better identify housing that places individuals at risk for lead poisoning. This data exchange, in which the Department of Health provides the Providence Housing Authority an address list for households in which children that were found to have high blood levels, gives the housing authority an efficient way to monitor housing in both conventional and Section 8 properties.

Provide a broader set of federal incentives for healthy housing policies. Current initiatives supported by HUD's Office of Health Homes and Lead Hazard Control focus on the reduction of physical hazards, such as environmental allergens, mold and moisture, and lead. However, the range of health problems identified by HOPE VI respondents suggests that a wider range of strategies is needed to significantly affect resident health. Mental and physical health problems identified by adult respondents extend far beyond the physical hazards found in government-owned buildings. As the full range of resident health needs come into focus, public housing authorities hoping to meet resident need will invariably have to partner with local health providers. Fortunately, models of successful health service partnerships between public housing authorities and local providers are beginning to surface. The medical research literature provides several examples where local health initiatives resulted in housing policy changes that had a direct impact on the health and well-being of public housing residents. Asthma and lead poisoning are two cases in which research and practice provide practical guidelines that can be implemented in a wide variety of settings. To promote these types of partnership for other health needs, housing policymakers should provide greater incentives for public housing authorities and community health providers to share information regarding client needs and coordinate services. Support for these types of incentives would broaden support services for public housing residents, and it would likely provide a stronger basis for resident self-sufficiency over the long term.

Notes

1. See Manjarrez, Popkin, and Guernsey (2007) for a review of the literature on neighborhoods and health outcomes.
2. Many health problems vary significantly by gender and race, and because over 88 percent of the adults in the HOPE VI Panel Study are women and 90 percent are black, a sample of black women nationally is used as the comparison group. The national data cited in this brief are published by the U.S. Department of Health and Human Services, calculated from the National Health Interview Survey (NHIS) in 2005. NHIS data are broken down by sex and race, but not further by poverty status. Nationally, approximately one-third of all black women live in households with incomes below the poverty level. Therefore, the comparison data are biased slightly upward in terms of better health because of the relatively better economic well-being of the national population of black women compared with the HOPE VI sample. However, even limiting the comparisons to similar gender, race, and age groups, adults in the HOPE VI study experience health problems more often than other demographically similar groups.
3. Based on other research, the proportion of residents returning will likely increase over time but will remain relatively low. Other research suggests that return rates overall have varied considerably from less than 10 percent to 75 percent, with the largest numbers returning in sites that were rehabilitated rather than demolished and rebuilt—not the case in any of these five sites. For other studies that have examined rates of return, see Holin, Buron, and Baker (2003); Buron et al. (2002); and National Housing Law Project (2002).
4. In both 2003 and 2005, respondents from Richmond's Easter Hill and Washington, D.C.'s, East Capitol were more likely to report poor health than the residents from the other three sites. In both sites, over 50 percent of the respondents identified their health as "fair" or "poor"; in East Capitol, this finding likely reflects the large proportion of older residents. In Richmond, it is probably related to the unusually high rates of asthma—more than 50 percent reported having been diagnosed with the disease.
5. The comparison data come from the 2005 National Health Interview Survey (NHIS).
6. Indication of mental health was based on a scale derived from the CIDI-12, or Composite International Diagnostic Interview Instrument. The series includes two types of screener questions that assess the degree of depression and the length of time it has lasted. The index is then created by summing how many of the seven items respondents reported feeling for a large share of the past two weeks. A respondent score of three or higher on the index indicates a major depressive episode.
7. The other MTO groups were given vouchers but could remain in public housing if they were not successful using their voucher. The following caveats apply to the comparability of the MTO and HOPE Panel Study samples: (1) MTO participants were volunteers and therefore were not a representative sample of residents; (2) MTO and HOPE VI sites were in different cities (except both included

Chicago); (3) the MTO interim evaluation was conducted four to seven years after the baseline year, whereas the HOPE VI interview was conducted four years after the baseline year; and (4) many public housing developments in the MTO cities were eventually made into HOPE VI developments so some of these residents may have been affected by HOPE VI as well.

8. This type of analysis was done for an earlier analysis of uprooted communities (Fullilove 2004).

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HOPE VI Program

Created by Congress in 1992, the HOPE VI program was designed to address not only the bricks-and-mortar problems in severely distressed public housing developments, but also the social and economic needs of the residents and the health of surrounding neighborhoods. This extremely ambitious strategy targets developments identified as the worst public housing in the nation, with problems deemed too ingrained to yield to standard housing rehabilitation efforts. The HOPE VI program is now up for reauthorization; if reauthorized, it will run for another 10 years.

The program's major objectives are

- to improve the living environment for residents of severely distressed public housing by demolishing, rehabilitating, reconfiguring, or replacing obsolete projects in part or whole;
- to revitalize the sites of public housing projects and help improve the surrounding neighborhood;
- to provide housing in ways that avoid or decrease the concentration of very low income families; and
- to build sustainable communities.

Under the \$6.3 billion HOPE VI program, HUD has awarded 609 grants in 193 cities. As of June 2006, HOPE VI revitalization grants have supported the demolition of 78,100 severely distressed units, with another 10,400 units slated for redevelopment. Housing authorities that receive HOPE VI grants must also develop supportive services to help both original and new residents attain self-sufficiency. HOPE VI funds will support the construction of 103,600 replacement units, but just 57,100 will be deeply subsidized public housing units. The rest will receive shallower subsidies or serve market-rate tenants or homebuyers.

HOPE VI Panel Study

The HOPE VI Panel Study tracks the living conditions and well-being of residents from five public housing developments where revitalization activities began in mid- to late 2001. At baseline in summer 2001, we surveyed a sample of 887 heads of households and conducted in-depth, qualitative interviews with 39 adult-child dyads. We conducted the second wave of surveys in 2003 (24 months after baseline) and the third and final wave in 2005 (48 months after baseline). In 2003, we surveyed 736 heads of household and interviewed 29 adults and 27 children; in 2005, we surveyed 715 heads of households and administered 69 interviews. We also interviewed local HOPE VI staff on relocation and redevelopment progress, analyzed administrative data, and identified data on similar populations for comparative purposes. The response rate for each round of surveys was 85 percent. We were able to locate, if not interview, nearly all sample members; the largest source of attrition was mortality.

The Panel Study sites are Shore Park/Shore Terrace (Atlantic City, NJ); Ida B. Wells Homes/Wells Extension/Madden Park Homes (Chicago, IL); Few Gardens (Durham, NC); Easter Hill (Richmond, CA); and East Capitol Dwellings (Washington, DC). These sites were selected as typical of those that had received HOPE VI grants in 1999 and 2000 but that had not yet begun revitalization activities.

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