THE CURRENT STATE OF HOUSING IN CANADA AS A SOCIAL DETERMINANT OF HEALTH

POLICY OPTIONS POLITIQUES

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Despite growing evidence as to their effect upon health outcomes, housing issues have not been high on the agenda of most health researchers in Canada and the federal government and many provincial governments have withdrawn from the provision of social housing over the last decade. Despite the housing agreements signed in November 2001 by the federal and provincial governments to build more social housing units, less than 200 new units have been built since then, if we exclude Quebec. To end the current housing crisis and insecurity, governments have to increase their spending on housing by 1 per cent of overall spending and adopt a national housing strategy that recognizes that housing affects the population's health and other social determinants of health.

Malgré ses effets de plus en plus documentés sur l'état de santé des gens, le problème du logement n'a que trop peu attiré l'attention des chercheurs en santé et des gouvernements au Canada. Depuis une dizaine d'années, Ottawa et plusieurs provinces ont tout simplement cessé de subventionner le logement social. Malgré les accords signés par les gouvernements fédéral et provinciaux pour augmenter la construction d'unités de logement en novembre 2001, moins de 200 nouveaux logements sociaux ont été construits depuis, si on fait exception du Québec. Pour mettre fin à la crise du logement et à l'insécurité qui en découle, nos gouvernements doivent augmenter de 1 p. cent les fonds alloués au logement dans leurs dépenses globales et adopter une stratégie nationale qui tienne compte des répercussions de ce problème sur la santé publique et les autres déterminants sociaux de la santé.

While there is increasing awareness of a housing crisis in Canada, there is little discussion of how housing issues—especially housing insecurity—are related to the health of Canadians. As documented by federal NDP leader Jack Layton in his book *Homelessness: The Making and Unmaking of a Crisis* (2000), according to many indicators—the number of Canadians who sleep in the streets, who use temporary shelters and who spend more than 30 or 50 percent of their income on housing—Canada's housing policy has clearly failed to meet the needs of a significant proportion of Canadians.

The purpose of this article is to consider how housing insecurity in Canada can be conceptualized as a social determinant of health. In 1986, the World Health Organization's *Ottawa Charter for Health Promotion* recognized shelter as a basic prerequisite for health, but it is only recently that researchers have focused on housing as an important determinant of health. Reasons for the neglect of housing as a health issue will be considered, and studies that demonstrate the link between housing and health will be reviewed. Policy changes that have led to the crisis in housing will be reviewed, and new ways of thinking about how housing insecurity is related to health and to a number of other social determinants of health will be presented. Finally, a model of policy change that identifies means by which these kinds of issues can be considered within the context of government policy-making will be outlined and policy solutions offered.

The current housing crisis and associated housing insecurity being experienced by Canadians are the results of radical changes in housing policy over the last two decades. The problem of affordability in the private rental housing market first emerged as a major issue in the early 1980s, and it remained for the most part not addressed through the 1990s. Housing is now seen as a national disaster. The federal government has even appointed a Co-ordinator of Homelessness. Layton's book outlines the dimensions of the housing crisis in Canada, and J. David Hulchanski's December 2002 report for the Canadian Policy Research

Network provides a history and analysis of the current status of Canadian housing policy.

Many analysts attribute the growing number of homeless and insecurely housed Canadians to reduced state involvement in housing. Indeed, J. David Hulchanski notes that Canada now has the most private-sector-dominated, market-based system and the smallest social housing sector of any Western nation, with the exception of the USA. Other factors include continuing high levels of unemployment and lack of affordable rental accommodation. The result is increasing numbers of families and individuals who are underhoused, living in motels, dependent on the shelter system or living on the street.

The 1990s marked the withdrawal of the federal government and many provincial governments from the provision of social housing. Social housing reflects a commitment by the state to support affordable housing for all. One illustration of the process of governments' withdrawal from the provision of housing for Canadians is the Ontario Progressive Conservative government's reversal in 1995 of 25 years of commitment by Ontario to providing housing for its citizens. As shown in figure 1, there has not been a single social housing start in Ontario since that time, with the not surprising result that the use of shelters has increased significantly. Layton reports that 1998 saw 1,000,000 overnight stays in emergency shelters in Ontario communities alone.

Shelter use is up across Canada. National data are not available, since not every province collects data on shelter use. In his book on homelessness, Layton reports that on an average night shelter use is approximately 300 people in Vancouver, 1,200 in Calgary, 460 in Ottawa, and about 4,000 in Toronto. The numbers have increased in Toronto, Calgary, Edmonton, Hamilton and Mississauga. The Federation of Canadian Municipalities reported that in 1996, 43 percent of households across Canada spent more than 30 percent of their income on rent. That same year, over 21 percent of Canadian households spent more than 50 percent of their income on rent, an increase of 43 percent since 1991.

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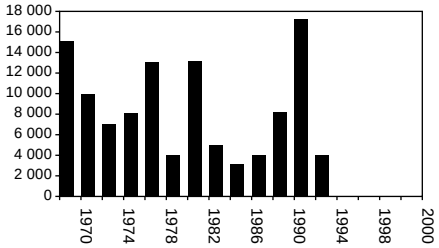
Figure 1
Social Housing Starts in Ontario (Mostly Co-ops, Nonprofits) 1970-2000



Source: Ontario Ministry of Municipal Affairs and Housing, 2001

It hardly seems necessary to argue the case that housing is a health issue, yet surprisingly few Canadian studies have considered it as such. In the UK, where the housing and health tradition is more established, numerous studies have shown strikingly high incidences of physical and mental health problems among homeless people compared with the general population. Wendy Bines, in *The Health of Single Homeless People* (1994) reported on the health problems of 1,280 homeless people in the UK. People who used hostels, bed and breakfast accommodation, day centres and soup runs were much more likely to have musculo-skeletal and chronic breathing problems, headaches, skin ulcers, seizures and other complaints. Those sleeping in the streets had the most severe health profiles.

The 1992 *Street Health Report*, a survey of the homeless population in Toronto, found that homeless people were at much greater risk than the general population for a variety of chronic conditions including respiratory diseases, arthritis or rheumatism, high blood pressure, asthma, epilepsy and diabetes. Despite this evidence, housing issues have not been high on the agenda of most health researchers in Canada. One reason may be the difficulties presented by this area of study for those trained in traditional epidemiological methods.

Epidemiology is defined as the distribution and determinants of diseases and injuries in human populations. Epidemiologists aim to identify the unique causal effects of single variables upon health outcomes through various experimental and correlational procedures. The identification of the health effects of housing does not easily lend itself to such a model. Living in disadvantaged housing circumstances clusters with a variety of other indicators of disadvantage. Indeed, Mary Shaw and her colleagues argue in *The Widening Gap: Health Inequalities and Policy in Britain* (1999) that "Health inequalities are produced by the clustering of disadvantage—in opportunity, material circumstances, and behaviours related to health—across people's lives."

When epidemiological research has considered housing, it has tended to focus on aspects of housing and health that can be isolated for measurement such as the presence of mould and the impact on respiratory infections in children, or overcrowding and its impact on mental health. But it has used models that attempt to identify the effects of these factors

independently of the contextual variables associated with disadvantage in general. Figure 2 is an example of a traditional epidemiological model that could be deployed to examine the relationship between housing and health.

The model identifies the material conditions of housing, such as mould and drafts, as areas of prime interest. Studies attempt to control for the effects of research participants' personal characteristics. They then distill the unique effects of housing conditions from other potential variables that may influence health. The approach searches for the association between the material aspects of housing independent of personal characteristics and other health determinants.

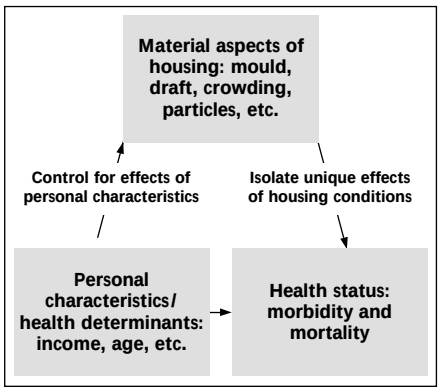
Unless studies are longitudinal and are based on very large numbers, the results produced by these analyses are frequently exercises in ambiguity. They usually say little about how life situations interact with policy environments to create these situations of disadvantaged housing. They also say little about the relationship between housing and other social determinants of health. Research that attempts to isolate the effect of poor housing is unable to measure or capture the complexity of and interaction among the determinants of health.

Nevertheless, when extensive studies are carried out, housing disadvantage is a unique predictor of poor health outcomes. Alex Marsh and colleagues reported on these issues in the 1999 UK report *Home Sweet Home: The Impact of Poor Housing on Health*. They drew upon the very large longitudinal database from the *National Child Development Study* to study the link between housing and health in more than 13,000 citizens. They found housing played a significant and independent role in health outcomes.

Greater housing deprivation during childhood and adulthood each contributed to severe/moderate ill health at age 33 years. Overcrowding was related to respiratory and infectious diseases. For those who experienced overcrowding in childhood to age 11, there was an increased likelihood of experiencing infectious disease. In adulthood, housing deprivation is linked to an increased likelihood of respiratory disease.

Such studies, while identifying potential relationships, focus on individual characteristics rather than the broader factors that influence health and well-being. They oversimplify the relationship between housing and health and other social determinants of health. New ways of thinking about housing and its relationship to health are needed.

Figure 2
Traditional Epidemiological Model of the Housing and Health Relationship



Geographer James Dunn of the University of Calgary and colleagues are identifying—with funding from the CIHR Institute of Population and Public Health—gaps in Canadian understanding of the housing and health relationship. They have developed a thoughtful population health framework of housing as a socio-economic determinant of health. Since studies have demonstrated a positive association between social status and health status, Dunn states "Housing, as a central locus of everyday life patterns, is likely to be a crucial component in the ways in which socio-economic factors shape health" (see *Housing as a Socio-Economic Determinant of Population Health: A Research Framework*, 2002). The authors outline three aspects of housing that are especially relevant to population health.

> The availability and affordability of housing plays an important role in relationship to other social determinants of health. People can go without many things, but going without housing is potentially catastrophic.

- *Material dimensions* of housing are concerned with the physical integrity of the home such as state of repair; physical, biological, and chemical exposure; and housing costs. Dunn notes that housing costs are critical because they are one of the largest monthly expenditures most people face. When housing costs eat up the majority of a person's income, it affects other aspects of their lives, an issue considered below.
- *Meaningful dimensions* of housing refer to one's sense of belonging and control in one's own home. Home is also an expression of social status—prestige, status, pride and identity—all of which are enhanced by home ownership. These dimensions provide surface for the expression of self-identity, and represent permanence, stability and continuity in everyday life. One would expect living in crowded or substandard housing to have profound health effects, as one would the worse case of being housed in a shelter or living on the streets.
- *Spatial dimensions* of housing refer to a home and its immediate environment, for example, the proximity of a home to services, schools, public recreation, health services and employment. While these include systematic exposure

to health hazards—toxins in the environment and asbestos insulation—they are also about the geographic availability of resources and services in relation to one's abode. This consideration introduces the need for understanding the policy dimensions associated with the availability of resources and services in communities. These concepts should stimulate new ways of Canadian thinking about and studying the role that housing plays in health.

The availability and affordability of housing plays an important role in relationship to other social determinants of health. People can go without many things, but going without housing is potentially catastrophic. If citizens are required to spend increasing proportions of available resources on maintaining a roof over their head, the resources available to support social determinants of health such as food and educational resources are diminished.

The Daily Bread Food Bank 2002 fact sheet, "Turning our Backs on Our Children," showed that social assistance rates have not kept up with rents in Toronto. In 2001, a single parent, usually female, with one child, received 59 percent of Statistics Canada's low-income cut-offs. The average monthly welfare income of such a single parent would be $957, while rent for an average one-bedroom apartment was $866 and for a two-bedroom, $1027.

It is difficult to imagine how it would be possible for such a family to cover other important expenses such as food with that after-rent income. Plentiful evidence is available to indicate that lack of material resources contributes to illness and disease, a situation made worse by the stress and uncertainty of living in such conditions. This process is shown in Figure 3.

Unaffordable housing and housing insecurity do not occur in a vacuum. Figure 4 shows how policy decisions create the conditions that influence the availability and affordability of housing and other social determinants of health. The availability and cost of housing has direct material effects on health. Policy decisions can also reduce financial resources, with direct material effects on health. Both types of policy decisions contribute to housing insecurity, increased stress and increased incidence of social exclusion, illness and disease. This model identifies neoliberal ideology as being responsible for the declining availability of affordable housing and financial resources for many citizens.

Figure 3
Model Incorporating Additional Factors

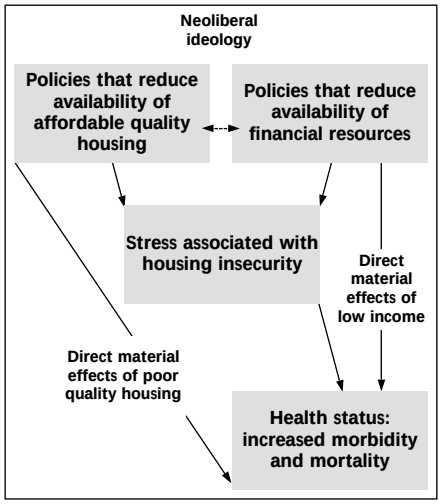
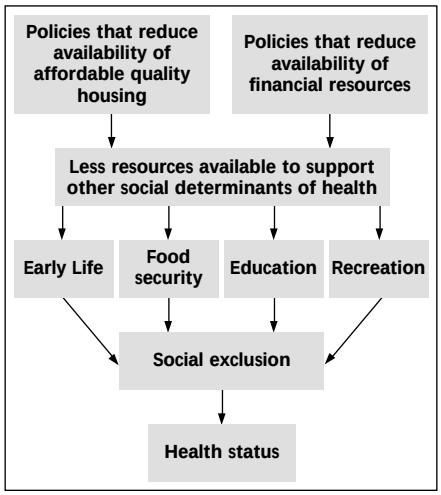
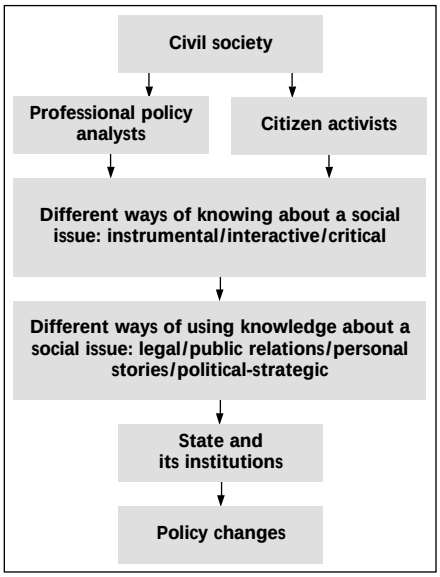


Figure 4
How Housing Affects Other Health Determinants



We need to understand how these developments have come about and to develop some means to new policy approaches toward housing. The policy framework in figure 5 was used to consider how the Ontario government used information to remove rent control.

Figure 5
Model Informing the Policy Change Process



I devised this conceptual framework as part of my dissertation research at the University of Toronto to guide case studies on housing policy and health policy change in Ontario since 1995. It incorporates elements of different forms of knowledge, the means by which this knowledge can be applied, and those who are likely to apply such knowledge. This framework can serve as a template for analyzing the policy change process on a case-by-case basis. It also provides insights into a government's general approach to policy change over time. It was used to consider how the Ontario government formulated its housing policies.

In Ontario, the government's political ideology emerged as a significant barrier to progressive housing policy change. Housing policy was found to be especially sensitive to political ideology, as the government's strong pro-privatization and pro-market agenda made

housing a ripe area for such activity. The Harris-Eves government perceived rent control and social housing as unfair impediments to private rental housing construction and considered the market to be the best allocator of rental housing.

The government's strong ideological bent predisposed it to ignore voices that opposed its policies. As a result of these policies, homelessness and housing insecurity in Ontario have exploded, while the government's predictions that the incentives of the removal of rent control would spur the construction of affordable housing have been found to be pathetically false.

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The housing situation in Canada requires a national housing strategy that recognizes that housing affects the population's health and other social determinants of health. By definition, the social determinants of health require intervention by all three levels of government. Risks associated with basic human needs require institutional or collective responses to social provision. We cannot rely on the market to concern itself with the determinants of health.

Housing advocacy groups have brought forward solutions to the housing crisis, in particular, to increase the availability of affordable housing and eradicate homelessness. The Toronto Disaster Relief Committee (TDRC) proposed the "One Per Cent Solution" to end the housing crisis. The TDRC argues that if all governments increased their spending on housing by 1 per cent of overall spending, the homelessness crisis could be eliminated in five years. The solution consists of three recommendations:

- Annual funding for housing of $2 billion from the federal government and another $2 billion from the provinces and territories
- Restoration and renewal of national, provincial and territorial programs aimed at resolving the housing crisis and homelessness disaster
- Extension of the federal homelessness strategy (Supporting Community Partnerships Initiative) with immediate funding for new and expanded shelter and services across the country

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Governments must be pressured to consider the social determinants of health in general and housing in particular as essential components of the policy-making process.

The federal and provincial governments have signed housing agreements that commit them to building more social housing units. Nevertheless, in December of 2002 the National Housing and Homeless Network reported that outside Quebec, less than 200 new housing units have been built since the housing agreement was signed in November, 2001.

Indeed, Canadians see little governmental activity to address these social determinants of health besides policy proclamations on housing and the other social determinants of health. Instead, emphasis continues to be placed on individual responsibility for health and the marketing of lifestyle approaches focused on tobacco use, diet and exercise. The reduction or dismantling of public programs that in the past responded to the needs of Canadians continues.

In spite of the ample evidence regarding the relationship between housing and health, government actions are frequently at odds with a social determinants approach to health. Governments are not seriously addressing social and health inequalities and the role played by housing policy in widening these inequalities. Political strategies are needed to highlight how these health and social inequalities threaten the health of all Canadians. To illustrate the difficulties to be surmounted, in 1991 Paul Martin—in all likelihood the next prime minister of Canada—authored a Liberal Opposition task force on housing, in which he stated:

> *The federal role in housing must not be a residual one. The connection between housing and other aspects of both social and economic policy means that the federal government must take a lead role…Our market housing system has not responded adequately to all of society's needs…The Task Force believes that all Canadians have the right to decent housing, in decent surroundings at affordable prices.*

After becoming finance minister, where he was well positioned to take action on the housing crisis, Martin chose not to implement the recommendations of his own task force.

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The Social Determinants of Health topic area within Healthy People 2020 is designed to identify ways to create social and physical environments that promote good health for all. All Americans deserve an equal opportunity to make the choices that lead to good health. But to ensure that all Americans have that opportunity, advances are needed not only in health care but also in fields such as education, childcare, housing, business, law, media, community planning, transportation, and agriculture. Making these advances involves working together to: Explore how programs, practices, and policies in Canadaâ€™s public health care system is one of the most generous in the world, but also quite expensive to maintain. In recent years, many provincial governments have started to scale back their scope of insurance coverage in order to make their medicare programs more financially sustainable, and Canadians often purchase supplementary private health insurance to pay for things like dentist trips, eye exams and any operation or treatment the government considers â€œnon-essential.â€Â All provincial health plans recognize gender dysmorphia â€” the medical name for the state of being transgender â€” as a valid medical condition, and will cover the costs of sex reassignment surgery (also known as gender-confirming surgery). Social determinants of health refer to a specific group of social and economic factors within the broader determinants of health. These relate to an individual's place in society, such as income, education or employment. Experiences of discrimination, racism and historical trauma are important social determinants of health for certain groups such as Indigenous Peoples, LGBTQ and Black Canadians. Health inequalities in Canada. Canada is one of the healthiest countries in the world. However, some Canadians are healthier and have more opportunities to lead a healthy life. Differences in the health Social Determinants of Health: Social Policy to Address Food In(security) in Canada. Social Policy. Adedolapo Elizabeth Onidare.Â Food as a social determinants of health. 3. society says what it means to be human and to have dignity in that cultureâ€ (SW 469.Â On 19 September 2017, the House of Commons. Standing Committee on Agriculture and Agri-Food began a study on a first food policy. for Canada, which is being established by the Minister of Agriculture and Agri-Food and. will be implemented over the coming year (House of Commons, 2017). The goals of this. policy are to produce safe, nutritious and affordable food in an environmentally friendly.

What are the 12 social determinants of health? 1. income and social status 2. Social support networks 3. Education and literacy 4. Employment/working conditions 5. Social environments 6. Physical environments 7.Personal health practices and coping skills 8. Healthy childhood development 9. Biology and genetic environment 10. Health services 11. gender 12. culture. 5 things involved in current state of SDoH. 1. empirical evidence 2. understanding mechanisms and pathways 3. role in life-course perspectives 4. role in policies related to SDoH science 5. role of political ideology.Â Canada Health Act? Federal Documentation. Ensures everyone has access to health care. Social Determinants of Healthâ€, Canadian evidence is included and supplemented by international evidence. It is recognized that there may be additional information not captured in this document, including particular exclusions of topics summarized elsewhere (e.g., long-term care facilities) and from developing countries. Relevant results are reviewed and data extracted for synthesis.Â Social Determinants of Health. COVID-19 risk factors originally focused on clinical conditions associated with severe COVID-19 outcomes, including age 65 and over and underlying medical conditions.Â Mortality among residents of shelters, rooming houses, and hotels in Canada: 11 year follow-up study. BMJ. 2009;339:b4036. The Social Determinants of Health topic area within Healthy People 2020 is designed to identify ways to create social and physical environments that promote good health for all. All Americans deserve an equal opportunity to make the choices that lead to good health. But to ensure that all Americans have that opportunity, advances are needed not only in health care but also in fields such as education, childcare, housing, business, law, media, community planning, transportation, and agriculture. Making these advances involves working together to: Explore how programs, practices, and policies in Canadian social programs have changed relatively little over the decades since their establishment, despite substantial transformations in the social and economic fabric of the country. Some have argued that Canadian medicare1 suffers a relative inertia in the face of broader social trends, making it difficult to change or build on.2 Since medicare was established, Canadians have experienced increased migration and cultural diversity,3 the transformation of family structures and gender roles,4 globalization, substantial changes to the economy5 and, in recent years, the growing threats.Â the socioeconomic and environmental determinants of health and wellness â€” are beyond the reach of the health sector.12. Health and Safety in Canada. Canadians are a generally healthy people and the country does not have any widespread problems with dangerous or infectious diseases. The average Canadian life expectancy is 80 years for men and 84 years for women.Â Housing in Canada. Canadaâ€™s home ownership rate is around 66 per cent.Â As Canada is a large and mostly uninhabited country, the risk of substantial human-caused environmental degradation is generally low, with worries centering mostly around the creation of new resource-extracting projects, such as mines, power plants, dams, or oil and natural gas wells or pipelines in previously untouched parts of the country.