Poverty, Housing Niches, and Health in the United States

Susan Saegert
City University of New York Graduate Center

Gary W. Evans
Cornell University

Drawing on psychological, health, and social science literature, a housing niche model is developed that focuses on (a) housing markets and other societal processes that constrain residential choice, (b) effects of residential environments on health and access to human and social capital, and (c) family dynamic effects on health and the intergenerational consequences of particular housing niches for future health and housing choices. The model requires the examination of cumulative risks, mediating and moderating processes, and the use of multilevel statistical models. The health consequences of existing housing policies are explored and future directions for research and policy suggested.

Even as the life expectancy of U.S. residents reaches new highs, death comes much earlier to residents of some neighborhoods, for example, Harlem in New York City (McCord & Freeman, 1990). Harlem’s residents are mostly poor and largely African American. Numerous studies demonstrate that both lower socioeconomic and minority status are strongly related to worse health and earlier death (Aday, 1994; Adler et al., 1994; Geronimus, Bound, & Waidmann, 1992;...
1999; Syme, 1994; Williams & Collins, 1995). Yet the higher mortality levels reported in Harlem exceed those for poor African Americans in other environments. Researchers are just beginning to examine the extent to which the concentration of poor and minority households in certain environments contributes to the health consequences of socioeconomic and minority status (Ellen, Mijanovich, & Dillman, 2001; Evans & Kantrowitz, 2002; Geronimus et al., 1999). This topic is particularly important since the spatial concentration of poor, and especially poor minority, households has increased over the last several decades (Jargowsky, 1997; Massey & Denton, 1993; Wilson, 1987).

In this article we develop a conceptual model of housing niches that relates health to housing and neighborhood conditions, social dynamics in the family and community, and overarching societal structures and processes. The purpose of this model is to shed light on the processes that underlie social inequalities in health and to understand their implications for policies designed to reduce these inequalities. In developing the model, we observe that (a) housing markets, income distribution, and other societal processes constrain residential choice; (b) environmental threats and assets in particular locations directly and indirectly affect health; and (c) opportunities and constraints in those locations also influence the residential choices and health of subsequent generations. This model emphasizes structural and policy determinants that establish the context within which people perceive choices related to residence and evaluate the threats and opportunities in their residential environment. Once households occupy particular housing niches, exposure to environmental threats and the psychosocial benefits of resources available in the housing niche have consequences for health. Within this model, psychological stress independently affects health and well-being, beyond the health effects of specific threats and resources. In addition, the consequences of individual stress for family dynamics can exacerbate stress experienced by other family members and so further undermine health.

In the following we first develop the housing niche model, describing the social production of housing niches; the effects of housing niches on health; cumulative, mediated, moderated, and multilevel risks in housing niches; and the life trajectories of individuals and housing niches. We then discuss public policy implications of the model. Although we emphasize the circumstances of those living in poverty as we proceed in our discussion, much of the literature we draw on reflects the fact that poverty is commonly confounded with race and ethnicity. Numerous studies confirm the negative health consequences associated with poverty for all populations and with minority status, especially African Americans, across the socioeconomic status (SES) spectrum (Adler et al., 1994; Evans & English, in press; Geronimus et al., 1999; Williams & Collins, 1995).
Housing Niches and Health

Two theoretical alternatives are usually posed to explain the differential spatial distribution of health (Ellen et al., 2001; Yen & Syme, 1999): Either people in worse health drift into certain areas, or particular places tend to breed ill health. In contrast, an ecological approach directs attention to the multilevel social processes that channel people to particular locations and also affect health (Bronfenbrenner & Morris, 1998). While personal choice and characteristics play a role in where people live, housing markets and policies set the context in which choices can be made. Subcultural and social network characteristics further affect the information and resources available to individual households, and their perceived and actual access to particular housing and neighborhoods (Pendall, 2000; Popkin, Buron, Levy, & Cunningham, 2000; Turner, 1998; Varady & Walker, 2000). For example, in the United States, race and ethnicity powerfully affect access to housing markets (Massey & Denton, 1993). Once a household is located in a resource-rich or resource-poor environment, exposure to the particular place has its own consequences (O’Connor, Tilly, & Bobo, 2001). Health and other consequences of living in a particular place in turn affect the assets that residents have for moving to better places (Ellen et al., 2001; Leventhal & Brooks-Gunn, 2000). Thus, in an ecological model, the correlation between residential environments and health develops over time through processes of both selection and exposure to differentially health-promoting or -impairing conditions (Smith, Easterlow, Munro, & Turner, this issue). Resources, physical environmental characteristics, and social processes shape each other in a dynamic relationship.

Social Production of Housing Niches

An ecological approach implies the existence of what we refer to here as “housing niches.” Housing niches are particular locations in the ecology of residential settings that can be occupied by specific groups. For example, buying an apartment in the wealthiest section of Manhattan requires mobilizing high levels of economic, social, and cultural resources. Adequate, moderately priced housing in areas more distant from the central city can be found through intense mobilization of social networks even if other resources are limited. Those with few financial and social resources are usually left to find homes in negligently managed, lower priced housing, in neighborhoods characterized by disinvestment, or in worse cases, to become homeless. Population health varies enormously across these different housing niches (Freudenberg, 2001).

The market-based provision of housing in the United States means that the kind of housing obtained is most dependent on the household’s accumulated wealth and disposable income. Poor households encounter problems related to both housing quality and affordability. In 1995, 4.8 million U.S. households lived in housing
that was structurally inadequate or overcrowded. Low-income urban renters encountered the highest number of deficits (Joint Center for Housing Studies, 1999). Such households find it increasingly difficult to access better quality housing. Housing costs for those in the bottom income quartile rose by 4.5% between 1995 and 1997 (Joint Center for Housing Studies, 1999). During the same period, incomes of renters in the lowest income quartile dropped by 2.9%. Production and availability of low-income units have also dropped. Compounding this problem, existing housing subsidy programs are expiring and many landlords are opting out (Dolbeare, 1999; Joint Center for Housing Studies, 1999; U.S. Department of Housing and Urban Development, 1999). Accordingly, the number of poor renters without housing assistance is at an all-time high; for some, housing costs exceed minimum wage levels by a factor of two or more. Not all can manage the cost. In the late 1990s, 5 to 10% of poor households experienced homelessness (Burt, 2002).

Racial segregation poses structural barriers to equal access to health-supporting residential environments. Several studies show that African Americans are sorted into housing niches characterized by both physical and social health hazards. Greenberg and Schneider (1994) found that residence in urban areas with hazardous land uses mediated an apparent association of violent deaths with race. LaViest (1989) documented higher Black infant mortality in more segregated communities that also had higher housing costs and lower wages for Blacks. Moreover, the housing stock in Black areas was older, and those neighborhoods were less well served by public services ranging from sanitation to health care. Disrespect among groups, especially of Blacks by Whites, income inequality, and residential segregation have all been found to undermine the health of low-income, minority populations (James, Schulz, & van Olphen, 2001; Kawachi, Kennedy, Lochner, & Prothrow-Stith, 1997; Subramanian, Kawachi, & Kennedy, 2001).

Wallace and Wallace (1998) trace the development of particularly disadvantaged housing niches in the South Bronx and Harlem. Economic declines and out-migration of wealthier, Whiter populations in parts of New York City were followed by institutional disinvestment leading to social fragmentation and housing insecurity for those who remained. As living circumstances got worse, the remaining resource-poor inhabitants were also most susceptible to homelessness, substance abuse, and violent crime. The fragmented social ties and deteriorated physical conditions of these communities, combined with few public services, were a favorable climate for AIDS and drug-resistant tuberculosis to take root.

In most of the research described thus far, weak social integration and low levels of social capital are correlated with hazardous residential environments and poor health. However, social capital itself is a factor that can affect access to particular housing niches, and which can be mobilized to improve environmental quality in these niches. Social capital is defined as a property of groups that facilitates the achievement of goals. It inheres in relationships characterized by trust, reciprocity, communication, shared norms, and consequences for norm violation (Coleman, 1988; Putnam, 1995; Warren, Thompson, & Saegert, 2001).
Finding a better place to live is a goal often achieved through the mobilization of social capital. For poor, minority, and immigrant households, the social groups within which they are embedded provide few resources of information, experience, contacts, or available financial capital for achieving this goal (Ratner, 1996). Oliver and Shapiro (1995) have argued that public policies and discriminatory institutional practices have worked against African American home ownership. Thus African Americans are often deprived of the major asset passed down across generations, the family home. Linguistic and cultural isolation of Latinos and Asians has also blocked access to home ownership (Listokin & Listokin, 2001; Ratner, 1996). However, some immigrant groups have used the strong norms, trust, reciprocity, and interdependence of their networks to accumulate financial capital to invest in home ownership (Ratner, 1996). In other cases, ethnically defined community advocacy groups help members of the community obtain information, advice, and credit to achieve home ownership (Listokin & Listokin, 2001).

Social capital within poor, minority communities can also be organized to improve existing housing and neighborhood environments. For example, mobilization of social capital among residents of very low-income, inner-city neighborhoods contributes to perceived housing quality (Saegert & Winkel, 1998) and less crime as measured by police records (Saegert, Winkel, & Swartz, 2002). Social capital also has played a critical role in the decision of residents of polluted industrial neighborhoods to take actions to improve air quality (Wakefield, Eliott, Cole, & Eyles, 2001). The development of social capital that links residents to community organizations, and these organizations to institutions and their resources, improves housing in poor communities and increases the supply of high-quality residential environments (Keyes, 2001).

Thus economic capital and social capital have many functions. Their unequal distribution contributes to the sorting of those with fewer resources into worse housing niches. Institutional practices are enmeshed in the distribution of these forms of capital and are critical in either routinizing this cycle of inequality or in finding ways out. Disadvantaged households, voluntary associations, and advocacy groups often try to use each form of capital to leverage others to improve access to and the quality of residential environments.

**Housing Niches’ Effects on Health**

Housing niches may contribute to health inequities through a variety of paths, including exposure to environmental toxins and nuisances, accident risks, and violence; the psychosocial dynamics of racism; access to environmental amenities; and levels of perceived control over life. These paths may exist on different levels, such as the physical housing unit and the neighborhood.

Despite relatively high housing standards, housing is receiving renewed attention in public health circles in the United States. Housing characteristics associated with health problems include dampness, pests, a lack of safe drinking
water, a lack of hot water for washing, and inadequate food storage (Matte & Jacobs, 2000). Poorly built or poorly maintained housing contributes to accidents, fires, respiratory disease, and lead poisoning (Matte & Jacobs, 2000; Sharfstein & Sandel, 1998; Warner, Barnes, & Fingerhut, 2000), as well as poor mental health (Evans, Wells, & Moch, this issue). Poor ventilation increases the risk of asthma and bronchial infections (Institute of Medicine, 2000; Oie, Nafstad, Botten, Magnus, & Jaakkola, 1999). The design and maintenance of windows, roofs, and balconies contribute to falls (American Academy of Pediatrics, 2001). Noisier housing can affect physiological stress (Evans, 2001) and has well-documented adverse impacts on reading acquisition in children (Evans & Lepore, 1993).

Many residential neighborhood characteristics can influence health. Crime and safety problems in neighborhoods contribute to injuries and death (Sampson, Raudenbush, & Earls, 1997) and impede physical exercise, thus increasing risk of poor health from many causes (Weinstein, Feigley, Pullen, Mann, & Redman, 1996). The siting of public parks, transportation policies, and other urban design decisions also influence access to opportunities for exercise (Brownson, Baker, Housemann, Brennan, & Bacak, 2001) and opportunities for psychologically restorative experiences (Hartig, Evans, Jamner, Davis, & Gärling, in press). Although the epidemiological path is less clear, studies have also shown associations between residence in neighborhoods with deteriorated and abandoned housing and gonorrhea (Cohen et al., 2000).

Disadvantaged populations occupy housing niches in which relatively high levels of exposure to health risks and low levels of access to environmental amenities can be seen at both the housing and neighborhood scale. Twenty percent of low-income American families have substandard housing according to U.S. Census criteria, as compared to 7% of those above the poverty line (Sherman, 1994). Low-income families in the United States are significantly more likely to have housing with inadequate plumbing systems, no central heating, and various structural defects (Mayer, 1997). Their homes are more crowded (Myers, Baer, & Choi, 1996) and they are exposed to greater levels of community noise (U.S. Environmental Protection Agency, 1977). American children in low-income homes have greater exposure to allergens linked to asthma (Krieger, Song, Takaro, & Stout, 2000; Sarpong, Hamilton, Eggelston, & Adkinson, 1996). At the extreme, many low-income children are homeless, with seriously negative consequences for their health (Wood, Valdez, Hayashi, & Shen, 1990). Parallel results for socioeconomic status and housing quality have been shown in the United Kingdom (Townsend, 1979) and several Third World nations (Bartlett, 1999; Garza, 1996; Stephens et al., 1997).

Air quality in low-income and minority neighborhoods in the United States is poorer (Brajer & Hall, 1992; Freeman, 1972), and disadvantaged families are significantly more likely to live near a hazardous waste source (Bullard, 1990; Mohai & Bryant, 1992; White, 1998). African American children living in inner-city areas carry a substantially higher body burden of lead (U.S. Environmental Protection
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Agency, 1992). Low-income, ethnic minority adults and their children are exposed more often to dangerous pesticides from multiple sources (Moses et al., 1993). Low-income neighborhoods are more hazardous for both children and adults. Disadvantaged children confront more dangerous street traffic (Macpherson, Roberts, & Pless, 1998) and more hazardous playgrounds (Suecoff, Avner, Chou, & Drain, 1999) than their more affluent counterparts.

Low social capital, which is more common in poor, minority neighborhoods and among renters, also contributes to poorer residential environments (Rohe & Stewart, 1996). As noted above, socially fragmented low-income, minority neighborhoods have poorer municipal services (e.g., access to medical care, police and fire protection, sanitation; Wallace & Wallace, 1998). Residents of low-income neighborhoods also have poorer mass transit and are less likely to own a car (Macintyre, Maciver, & Sooman, 1993). Their neighborhoods have fewer retail stores and services (e.g., laundry and dry cleaning; Macintyre et al., 1993) and are more apt to contain abandoned buildings and vacant lots (Joint Center for Housing Studies, 1999; Wandersman & Nation, 1998).

Low-income areas may not only have less social capital, they may also have poorer prospects for the development of social capital. Residential stability is strongly tied to income, with low-income families five times more likely to move involuntarily (Federman et al., 1996). Consequently, not only do low-income families themselves move more often, they live in neighborhoods with greater residential instability (Leventhal & Brooks-Gunn, 2000). It is not surprising then that poorer children experience greater instability in their peer relationships during childhood in comparison to middle- and upper-class children (Dodge, Pettit, & Bates, 1994). Also, they experience greater turnover in classmates at school (Rutter et al., 1974). Residential stability is also related to neighborhood homicide rates (Sampson et al., 1997). High crime rates and gang activity in urban low-income areas impede community life, further weakening the development and maintenance of social capital (Sampson et al., 1997).

Cumulative, Mediated, Moderated, and Multilevel Risks in Housing Niches

One goal of the housing niche model is to better understand the ways that psychological, social, and physical environmental factors contribute to health within a particular housing niche. Given adequate measurement, different conceptual and methodological approaches can illuminate the confluence of these factors. These include the use of cumulative risk models that combine risk factors from multiple domains, mediation models that examine processes that link particular conditions to outcomes, and moderation models that look at the interactions of individual characteristics and housing or neighborhood conditions, as well as interactions between housing and neighborhood factors.

An ecological model of housing and health emphasizes the covariation of environmental and social forces impinging on families. Rather than focusing on
single risk factors associated with the geography of poverty and minority status, an alternative strategy is to examine the accumulation of risk factors. Not only do disadvantaged individuals face higher levels of pollution, crowding, inadequate housing, and neighborhoods with inadequate infrastructure, but also they frequently experience these social and environmental demands in concert. For example, low-income and minority children experience more severe and higher numbers of stressful life events and hassles than their more advantaged counterparts (Attar, Guera, & Toaln, 1994; Brown, Cowen, Hightower, & Lotyszewski, 1986; Dubow, Tisak, Causey, Hryshko, & Reid, 1991). Low-income families both in Britain (Rutter et al., 1974) and in the United States face a greater array of risk factors in their homes and neighborhoods (Evans & English, in press; Liaw & Brooks-Gunn, 1994; O’Campo, Gielen, Royalty, & Wilson, 2000; Repetti, Taylor, & Seeman, in press). Chronic exposure to a high level of largely intractable demands is a major risk factor for both psychological and physical morbidity (Lepore, 1995).

Evidence increasingly shows that cumulative risk is more potent in accounting for both psychological and physical morbidity than singular risk factors (Rutter, 1981; Sameroff, 1998; Taylor, Repetti, & Seeman, 1997; Werner & Smith, 1982). Adults and children can often cope reasonably well with one or two adaptive challenges, even if severe. However, when the pressure of multiple demands begins to accumulate, the system is more likely to be worn down (McEwen, 1998; McEwen & Seeman, 1999).

Evidence suggests, also, that some of the well-known socioeconomic gradients in physical and mental health (Aber, Bennett, Conley, & Li, 1997; Adler et al., 1994; Chen, Matthews, & Boyce, in press; Duncan & Brooks-Gunn, 1997; Luthar, 1999; McLoyd, 1998) can be accounted for, at least in part, by income and class differentials in cumulative risk exposure. Here we can see the value of mediational models for elaborating the influences of housing niches on health. For example, elevated physiological stress and psychological distress in low-income rural elementary school children relative to middle-income children were largely mediated by cumulative exposure to multiple physical (e.g., poor housing quality) and psychosocial (e.g., family turmoil) stressors (Evans & English, in press). Low-income children relative to middle-class children residing in rural areas experience more crowding, noise, and inadequate housing in conjunction with elevated levels of family turmoil, family separation, and exposure to violence. The greater the accumulation of these multiple stressors, the stronger the adverse psychological and physiological consequences. Rutter (1981) demonstrated that combined risks at home and school substantially increased the likelihood of childhood pathology relative to risk in only one domain. He showed also that combined risk occurred more often among low SES families than in working-class families.

Thus, disadvantaged families living in inadequate housing situated in neighborhoods lacking social capital and basic infrastructure are situated in an ecology
of cumulative risk. In addition, the cost of housing itself exposes poor households to unhealthy living conditions such as poor nutrition. It depletes financial resources for health care and other forms of preventing and coping with disease. Housing is one of the largest expenditures in the budgets of low-income people (Edin & Lein, 1997; Stone, 1993). The poor pay so much of their incomes for housing that they must scrimp on other household needs.

Since the housing niche concept presumes the interdependence of people and environments, it suggests that characteristics of residents and of the residential environment may moderate the relationships described above. Any genetic weaknesses among poor populations may be more likely to express themselves in either poor health or health-endangering lifestyles because the residential environment provides an eliciting context for damaging genetic predispositions (Rutter, 1997). Deteriorated or polluted environments can lead to worse mental health for people who have other strains and stressful events in their lives, even when less taxed residents remain unaffected by the environment (Caspi, Bolger, & Eckenrode, 1987; Evans, Jacobs, Dooley, & Catalano, 1987).

Multilevel models are often the most appropriate way to examine interactions between household, building, or neighborhood context and personal characteristics. The development of Hierarchical Linear Modeling (HLM) and other multilevel statistical approaches has increased our ability to parse out the variance attributable to lower levels of analysis, for example, the individual, versus that attributable to higher levels such as neighborhoods. For example, a study of African American women found that the interaction between aggregate-level community characteristics and individual psychological processes explained why some women prospered or suffered more in particular community contexts (Cutrona, Russell, Hessling, Brown, & Murry, 2000). By employing multilevel models, the authors were able to overcome the bias created by the lack of independence of individual measures and the larger units into which they are aggregated. They could demonstrate that while aggregate-level ratings of neighborhood conditions were significantly related to individual residents’ levels of distress, individual-level risk factors moderated the relationship.

Life Trajectories of Individuals and Housing Niches

Understanding housing niches and their effects on individuals and households requires an examination of the mutual determination of housing niches, individual opportunities, and health. How does residing in resource-rich housing environments, or the opposite, position residents to improve their life circumstances, including health and housing? How does good or poor health affect access to health-promoting environments? This perspective has implications for understanding the intergenerational transmission of both health and residential options. Households who live in safe, friendly neighborhoods with good housing, schools, services,
and amenities would be expected over time to increase their access to resources and choices by employing the human and social capital they accumulate in such circumstances. Resource-poor residents located in places with poor housing, poor schools and services, and socially fragmented neighborhoods would be likely to experience ill health, lower levels of education and occupational attainment, and, over time, less access to resources and choices (Braconi, Louch, & Morse, 2000; Easterlow, Smith, & Mallinson, 2000).

Children growing up in these different environments are directly affected not only by living conditions, but also by the obstacles or supports in the environment for effective parenting (Leventhal & Brooks-Gunn, 2000). Parents in these conditions may be less able to promote healthy development for their children. Coping processes that both parents and children develop may protect them from threats, for example, limiting social relationships and exploration in dangerous environments. But these forms of coping may also have negative consequences for social ties and access to better housing environments and opportunities (Brooks-Gunn, Duncan, & Aber, 1997; Greenberg, Lengua, Coie, & Pinderhughes, 1999; Klebanov, Brooks-Gunn, Chase-Landsdale, & Gordon, 1997).

The weathering hypothesis (Geronimus, 1992) addresses the intergenerational implications of high levels of cumulative disadvantage among African American women. While Geronimus focuses on birth outcomes, her argument has implications for housing niche mobility as well. She documents that African American teen mothers have healthier babies than older African American women. She speculates that better birth outcomes may motivate teen pregnancies. She reasons that first, African American women’s health deteriorates faster and further than the health of White women; second, young mothers and their support networks are better able to cope with teens’ babies; third, grandmothers of teens’ babies are more physically capable of providing assistance; fourth, when daughters complete childbearing earlier, they are freer to help their mothers with the problems of aging. Support for the weathering hypothesis comes from an ethnographic study of the lives of mothers in Harlem. Mullings and Wali (2001) trace how environmental deprivations and social burdens associated with poverty undermine the physical and mental health of African American women from a wide range of socioeconomic circumstances and across the life span. Even the admirable norm among African Americans, to “give back” to their communities if their fortunes improve, exacts a cost in this ecology of cumulative risk. Housing niche mobility across generations is impeded by weathering itself, the interruption of education for childbearing, and the strong intergenerational interdependence fostered by inadequate incomes and nonfamilial sources of support.

The weathering hypothesis emphasizes not only the social structural context that constrains the choices of African American women, but also the critical roles of stress and risk behaviors within this set of constraints. The burden of cumulative risk and accumulated health problems may translate into less adequate
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Parenting, which may itself further undermine their children’s development. Studies of African American and Latino mothers and children in New York City public housing revealed that children’s reactions to two socioenvironmental stressors depended on their relationships with parents, and family dynamics more generally. Evans and Saegert (1999) demonstrated the critical role of parenting in determining children’s vulnerability to psychological distress in the face of residential crowding. We found that children experienced more psychological distress and more physiological stress under conditions of crowding and family turmoil. However, when parents were able to avoid harsh treatment of children in these stressful conditions, children did better. Similarly, Krenichyn, Saegert, and Evans (2001) found that while exposure to community violence took a very large toll on the mental health, physiological functioning, and social development of children in New York City’s public housing, parenting moderated these effects. Children exposed to both harsh parenting and community violence fared worse than those experiencing only one of those threats. Further, children exposed to violence in the context of supportive parenting developed the highest level of self-reported competence in the sample. These studies suggest that when parents’ behavioral adaptations to stressful environments affect children’s experience of stress, the ground may be laid for the intergenerational transmission of disadvantage by interfering with healthy development, thus making it more difficult for the next generation to find its way out of poor housing niches.

Public Policy and Housing Niches

The housing niche concept builds on Link and Phelan’s (1995) argument that to understand the relationship between poverty and health we need to contextualize risk factors—that is, attempt to understand how people come to be exposed to individually based risk factors such as poor diet, cholesterol, lack of exercise, or high blood pressure, and to view the social conditions that contribute to risk exposure as themselves fundamental causes of disease:

A fundamental cause involves access to resources...that help individuals avoid diseases and their negative consequences through a variety of mechanisms. Thus even if one effectively modifies intervening mechanisms or eradicates some diseases, an association between a fundamental cause and disease will reemerge. As such, fundamental causes can defy efforts to eliminate their effects when attempts to do so focus solely on the mechanisms that happen to link them to disease in a particular situation. (Link & Phelan, 1995, p. 81)

We argue that the economic and social processes that channel the poor into inadequate housing niches are fundamental social causes of ill health because they cascade into multiple specific mechanisms that undermine health and reinforce differential access to healthy and unhealthy niches. One implication of this position is that even public policies aimed at improving either housing or health are likely
to fail if they do not fundamentally change the underlying economic and social dynamics.

Public housing in the United States provides a good example of how impoverished housing niches develop and become entrenched (Newman & Schnare, 1997; Spence, 1993). From Lee Rainwater’s (1970) account of “life in a federal slum” through Alex Kotlowitz’s (1991) aptly titled book, There Are No Children Here, the dominant image of U.S. public housing is bleak. The National Commission on Severely Distressed Public Housing (1992) concluded that the social isolation and institutional abandonment of public housing residents was an even greater problem than the physical decay of public housing developments. Nationally, public housing has been located in the most devastated neighborhoods and served the most destitute populations (Goering, Kamely, & Richardson, 1997; Newman & Schnare, 1997). Community violence has been a particularly dramatic problem for public housing residents. In 1998, the U.S. Department of Housing and Urban Development (HUD) reported that an average of one gunshot-related homicide a day occurred in the 100 largest public housing authorities.

Recognition of the problems associated with public housing led to the creation of HUD’s Moving to Opportunities (MTO) Program. Implemented in Baltimore, Boston, Chicago, Los Angeles, and New York City, the MTO program relocated public housing residents from areas of concentrated poverty into geographies of greater opportunity. Early evaluations reveal positive effects on the quality of life and the mental and physical health of public housing residents who were selected to move and accepted this opportunity. Employing a randomized experimental design, MTO assigned families who volunteered to one of three conditions: (a) suburban movers, who were required to move to a suburban, low-poverty area and received assistance in finding housing; (b) free choice movers, who used their subsidies to find housing without assistance; and (c) a control group who remained in public housing. All were expected to pay no more than 30% of their income in rent.

Although evaluation methods and findings differed across cities, early results paint a fairly uniform picture of improvement in neighborhood quality for suburban movers. About 90% of suburban movers relocated to census tracts with less than 10% poverty rates. About 75% of free choice movers went to tracts with poverty rates ranging from 10% to 39%. Most of the control group remained in tracts of concentrated poverty (over 40%). Evaluations from Boston, Chicago, and New York all found that both mover groups described their new neighborhoods as physically better and safer (Katz, Kling, & Liebman, 2001; Leventhal & Brooks-Gunn, in press; Rosenbaum & Harris, 2001, 2002). The Chicago evaluation also assessed changes in housing conditions and found that while all movers reported better housing conditions, those of suburban movers improved most. Housing characteristics that showed most improvement all had potential health and safety impacts: peeling paint, the presence of mice and rats, and problems with broken locks (Rosenbaum & Harris, 2002).
Comparisons of MTO baseline data with data gathered 2 to 3 years after moving indicated improvements in the physical and mental health of parents and children. In Boston, both groups of movers reported improved health for the head of the household. Children in the suburban group also experienced reductions in injury, asthma attacks, and victimization by crime (Katz et al., 2001). Chicago and New York mover households were much less frequently the victims of crime, including reduced incidents of shooting, stabbing, and beating (Leventhal & Brooks-Gunn, in press; Rosenbaum & Harris, 2002). In New York, the physical and mental health of both parents and children improved most for suburban movers and slightly for free choice movers (Leventhal & Brooks-Gunn, in press). Parents in the New York experimental group reported less reliance on harsh parenting tactics after the move. Also in New York, both mover groups increased their levels of employment, and the suburban movers improved the household’s overall level of economic resources.

Social capital is the one area in which findings are mixed regarding MTO. In Chicago, suburban movers reported the weakest neighborhood ties and more isolation as a result of an absence of public transportation (Rosenbaum & Harris, 2002). In New York, parental engagement with children’s school activities was lowest for the suburban movers although they participated more than nonmovers in school governance activities (Leventhal & Brooks-Gunn, in press). The importance of social ties to public housing residents may be one reason that the majority of MTO participants who were assigned to the experimental conditions did not actually move to wealthier, Whiter suburbs. These 52% had volunteered to participate in MTO but when they were chosen, they declined to move or failed to complete the move successfully (Goering et al., 1999). Those who did not take the treatment, as well as those who did not participate in the study, are likely to have been embedded in stronger social networks.

When a program specifically attempts to overcome housing segregation by race and class, the housing niches occupied by low-income and minority households who choose to participate can significantly improve. But it is important to try to understand the social processes that helped the suburban movers gain access to their new homes. The greater improvement of the suburban movers compared to the free choice movers suggests that institutional assistance in overcoming housing segregation does convey health benefits. This finding accords with the view that the cost of housing alone does not explain segregation by class and race into less advantaged neighborhoods and worse housing. Discrimination and the limited social capital of poor, minority households also figure in the problem.

The early results of the Moving to Opportunity Program suggest that it is possible to find ways to equalize access to housing with consequent benefits for health. But deconcentration programs are expensive, do not reach many poor households, and do not always work (Pendall, 2000; Popkin et al., 2000; Turner, 1998; Varady & Walker, 2000). U.S. initiatives to increase home ownership among lower income,
minority, and female-headed households may also assist poor households in improving their housing niches. These changes in the provision and distribution of housing would have to reverse U.S. trends in the past two decades toward growing inequality in income and quality of life (Danziger & Gottschalk, 1994). Despite the successes of federal programs to increase home ownership among minorities and immigrants, these groups still lag, with minority home ownership rates less than two thirds of those of Whites. Efforts to disperse recipients of housing assistance also have only partially succeeded, resulting in slightly better housing still in primarily minority, low-income areas (Pendall, 2000; Popkin et al., 2000; Turner, 1998; Varady & Walker, 2000).

The general broadening of the housing affordability gap (Dolbeare, 1999; Joint Center for Housing Studies, 1999; U.S. Department of Housing and Urban Development, 1999) may swamp the gains made by specific demonstration projects and programs, thus contributing to greater health disparities. However, as Link and Phelan (1995) point out, careful program planning, evaluation, and research can help us learn what puts people at risk for risk. If we truly seek to eliminate health disparities, their recommendations continue to be good advice: Programs should give priority to interventions that affect multiple causes of ill health, while regarding with skepticism interventions that focus on intervening mechanisms without situating these in broader social and physical contexts (p. 89). Taxation, minimum wages, mortgage underwriting criteria, access to high-quality education, and discrimination (or its prohibition) in housing, work, and education are among the many policies and institutional practices that can increase or reduce inequality in society. These policies and practices, perhaps as much as those directly related to health, are likely to affect social disparities in health. One of the major ways in which this occurs is through the sorting of the poor into disadvantageous housing niches that directly and indirectly threaten health.

Other articles in this issue suggest that public policy commitments to improved housing can benefit the health of populations. However, studies have shown that lower SES is associated with poorer health even for those who are not at the extreme end of deprivation (Adler et al., 1994). Using the housing niche concept, it may be that even within SES groups, housing distribution systems translate small differences in SES into significantly different residential ecologies.

Communities lower in social capital result in stronger gradients associating lower status with poorer health (James et al., 2001), but social capital within poor communities can only go so far. Strong social ties, norms of trust and cooperation, and intergenerational closure can support physical and mental health and child development. However, social capital has limited utility in connecting these communities with more resources. For that to occur, poor households and communities must develop leaders, institutions, and organizations that make claims on the broader society (James et al., 2001; Saegert & Winkel, 1998; Warren et al., 2001). In addition, governmental programs and actions by mainstream financial
and social institutions must cease reinforcing, rather than reducing, the social and economic marginalization of poor communities and households (Duncan, 2001; Lopez & Stack, 2001). Public programs and institutional practices are needed that support, rather than undermine, social and human capital and provide access to better housing, education, jobs, and opportunities.

Our housing niche model and the policy-related arguments based upon it suggest the need for research on the following questions:

1. To what extent do poverty and racism lead to residence in environments that expose people to higher levels of environmental stressors and cumulative risks? To what extent do those exposures mediate health outcomes?
2. What multilevel social processes offset or magnify the negative consequences of exposure to environmental stressors and risks?
3. How is access to housing environments mediated by the social and human capital of poor people and by public policies?

Only longitudinal studies can determine the individual and intergenerational life trajectories of residents in particular housing niches who vary in health, economic, and social status. The strengths families and social networks bring to overcoming ecological disadvantages also require study. These should include not just well-studied factors such as personal resiliency and social support but also family dynamics and characteristics of social networks that not only resist damage but move households and communities into more promising ecologies.

References


Poverty, Housing Niches, and Health


SUSAN SAEGERT is Professor of Environmental Psychology and Director of the Center for Human Environments (CHE) at the City University of New York Graduate Center. Her current research examines the linkages between urban housing and neighborhoods and health, and how community processes, especially those related to social capital, contribute to better urban environments.
GARY W. EVANS is Professor of Design and Environmental Analysis, College of Human Ecology, Cornell University. He is an environmental and developmental psychologist primarily interested in the role of the physical environment in socio emotional development. Current research is focused on housing, noise, crowding, and the environment of poverty.