

Housing Policy and Home-Based Care

SANDRA J. NEWMAN

Johns Hopkins University

SEVERAL PROMINENT SOCIAL AND DEMOGRAPHIC trends—women's increased attachment to the labor force, changes in the nature of the family, and the growth of the elderly population—have stimulated new interest in home and community-based services. Despite the continued responsiveness and durability of family support systems, interest in formal services has been particularly strong for at least two reasons: the often substantial social costs of family care and the service gaps experienced by those with no viable family caregiving systems.

Partly in response to these concerns, researchers have attempted to gain a better understanding of the need and demand for formal services in the home. Studies have addressed such questions as who uses in-home services, what conditions precipitate their use, and what effects they have on users (e.g., Berkeley Planning Associates 1985; Mindel et al. 1986; Wan 1987; Mathematica Policy Research 1987; Tennstedt and McKinlay 1987; Noelker and Bass 1989). Little attention, however, has been paid to the question of *how* the formal service system functions or, more particularly, to the factors that *enable* this system to function successfully. Although public policy can do little to alter family demographics or the amount of affection and caring within families, exogenous factors that either facilitate or impede home and community-based care access and

The Milbank Quarterly, Vol. 73, No. 3, 1995

© 1995 Milbank Memorial Fund. Published by Blackwell Publishers, 238 Main Street, Cambridge, MA 02142, USA, and 108 Cowley Road, Oxford OX4 1JF, UK.

quality are appropriate targets for policy consideration. One such enabling factor may be the housing environment in which the individual in need of care lives. Because, by definition, the individual's home is the setting in which home-based, long-term-care services are delivered, it is plausible to expect that characteristics of that setting may affect how, or what, care is provided, or even whether it is feasible to provide care at all. For example, features of the housing environment, such as the size and configuration of the dwelling and the characteristics of its neighborhood, may either facilitate or prevent links with needed home-based services. Even more fundamentally, housing can have a dramatic effect on the ability of a chronically ill or disabled person to continue to live independently in the community (Thomas 1983). In some cases, the ability to make physical modifications to the dwelling or property may determine whether a person with severe mobility problems can remain at home (Struyk and Katsura 1988; Pynoos et al. 1987). Thus, housing arrangements can be an important element in designing cost-effective policies to help sustain the chronically ill or disabled in the community.

The premise that housing can affect functioning and continued community living has already had a substantial impact on developments in the public and private housing sectors, such as housing design standards for the disabled and a range of special design features in both the federally subsidized Section 202 Housing Program for the Elderly and Handicapped and private sector life-care and assisted-living community developments. Under a broader definition, the nation's housing policies—particularly those designed to meet the needs of low-income or otherwise vulnerable households—are relevant to home-based, long-term-care policy. Because housing policy often has a direct impact on the structural and neighborhood characteristics of the housing stock, it is important to consider the role such policy may play in the delivery of home-based care to persons who need it.

In this article, I present a critical review of housing policies that are relevant to home-based care—the range of health and social services delivered to disabled persons in their homes or communities. In the first two sections, I establish the context for this review: first, by highlighting research findings on the link between housing and home-based care; and second, by providing a brief legislative history of the view of health issues within housing policy over time. In the next three sections, I examine the primary ways in which housing policy affects home-based care:

financing mechanisms; regulations and statutes; and coordination. In the final section, I offer some broad targets for policy that might foster greater coherence between housing and home-based care policies, with the ultimate goal of increasing home-based-care access, quality, and options.

Housing and Home-Based Care: A Review of the Research Evidence

Knowledgeable observers make a strong case for the effects of housing on home-based care. For example, Eustis, Kane, and Fischer (1993) offer the hypothesis that “structural features of the job” may affect the quality of care provided by home care workers; one plausible structural feature is the housing environment. Based on their experience with the Chelsea Village Home Care Program in New York City, Scharer, Berson, and Brickner (1990) support this hypothesis: “Providers are increasingly concerned about their ability to deliver good quality care in unsafe neighborhoods and deteriorating home environments” (p. 518). Unfortunately, very little research has been done to examine systematically the effect of particular housing attributes either on the probability of arranging for home-based care services or on the effectiveness of these services. The scant research that has been done focuses on two population groups: the elderly and persons with severe mental illness.

Sussman (1979) and Noelker (1982) provide empirical evidence on the ways in which housing affects family caregiving to the elderly. Sussman (1979) found that situational variables, including a small number of housing characteristics, appeared to facilitate a family’s willingness to care for an elderly relative (see also Sangl 1983). Noelker (1982) also highlighted the potential modifier effects of housing, primarily by emphasizing features that may impede family care, such as lack of privacy or insufficient space.

My own study (Newman 1985) of the suitability of dwellings and neighborhoods for the delivery of in-home care extended this hypothesis to the purchase of formal services like home-based care. I found that roughly 17 percent of the elderly population who might be able to remain in the community and receive in-home and community-based services are living in housing units and neighborhoods that either impede the efficient delivery of these services or preclude their delivery altogether.

These impediments include physical features of the dwelling, such as lack of space or special modifications, that would make it difficult, if not impossible, to accommodate long-term-care service delivery in the home, and features of the building (number of units in structure) or neighborhood (low density of dwellings) that are likely to increase the cost of service delivery because of the absence of economies of scale.

In later research, my colleagues and I (Newman et al. 1990) tested this finding more rigorously, particularly two key hypotheses that explored, first, the *direct* effect of housing and neighborhood attributes on the chances that a frail older person will enter a nursing home, and, second, the *indirect* effect of these attributes in terms of the ability to provide informal or formal care to the older person in the community. We found that some informal caregivers—spouses, for example—appear to be aided in their caregiving by the presence of special dwelling modifications in the home. These modifications include such features as grab bars, ramps, or specially equipped bathrooms. In addition, a small number of environmental features played a significant role in the efficacy of formal, paid, home-based care. Adequate space in the dwelling, for example, appeared to be an enabling factor that strengthened the deterrent effects of formal care on the impaired person's institutional risk. Thus, although environmental features did not directly affect institutionalization, a subset of them had indirect effects.

Recent research on another population group—persons with severe mental illness—suggests a relationship between utilization of home and community-based care services, residence in affordable and physically sound housing, and beneficial outcomes (Newman et al. 1994). Using data from a longitudinal survey of severely mentally ill persons who were using Section 8 rental housing certificates, the researchers found that the combination of affordable, decent housing and the availability of support services increased residential stability and decreased the average number of hospital days per year and service needs.

Taken together, this body of work, albeit limited, suggests that the effects of informal or formal care—including home-based care—on a host of outcomes like institutionalization, hospital length-of-stay, and residential stability may depend in part on the presence or absence of an accommodating environment. For the frail elderly, for example, a spacious, flexible, or convenient setting may simply make it easier to deliver long-term-care services or may even increase their quality and effectiveness. For persons with severe mental illness, access to a decent, safe, and sanitary

dwelling was found to be significantly associated with a decline in gaps in needed home and community-based services, and both decent housing and supportive services were associated with beneficial outcomes.

By providing some empirical basis for the relationship between housing and neighborhood characteristics and home-based care, this research literature also provides some justification for examining how housing policies may encourage, or discourage, home-based care. Further research, however, into such issues as the role of housing or other contextual characteristics in the decision to utilize home-based care services, the quality of those services, and their cost could strengthen this justification substantially. The practical importance of learning more about housing and home-based care is that if particular housing attributes are found to contribute to continued residence in community settings, in part because of their effects on home-based-care feasibility, quality, or costs, then it may be possible to reproduce these features for other members of the “at risk” population (Struyk and Zais 1982; Newman 1985).

Before turning to the specific housing policies that are most relevant to home-based care, it is useful to provide a broader context for this review. In the next section I will describe one facet of the evolution of housing policy, namely, how it has historically viewed concerns about the health of occupants.

Housing and Health: A Historic Perspective

The relationship between housing policy and health policy in the United States has had a checkered history. Perhaps the strongest link existed during the 1920s and 1930s, the earliest years of housing policy development, when the deleterious effects of substandard housing were used as a primary rationale for developing a national housing policy. Programs like slum clearance, the creation of public housing, and the introduction of standard building codes can all be traced to the underlying notion that housing affects health. Frequent references to “healthful living conditions,” particularly for families with small children, can be found in early iterations of the National Housing Act and associated regulations. There is also some evidence of collaborative efforts in these early years between health professionals (e.g., the American Public Health Association) and housing professionals (e.g., the National Association of Hous-

ing and Redevelopment Officials). For example, at the national level, health and housing groups worked together to develop broad policy goals regarding healthful housing; in some states and localities, interagency groups created mechanisms to implement these goals.

Until very recently, it would have been fair to say that this shared vision of the early years has been on the decline ever since. As in many areas of social welfare policy, after World War II housing policy entered a period of specialization, regulatory complexity, and bureaucratic expansion. Undoubtedly, the most significant benefit associated with this evolution was the steady improvement in physical housing conditions over time to the point where only a nominal fraction of the housing stock is generally considered inadequate (Weicher 1980). One clear cost, however, was the disincentive for housing and other agencies to coordinate their policies, including those pertaining to health.

There have been a few intermittent exceptions to this pattern. Perhaps the most prominent was the investigation of the deleterious effects of lead-based paint on children's health, which led to legislation governing the use of lead-based paint in residential settings. Another example was the development of dwelling modification standards for the physically handicapped (Steinfeld 1975).

Recent shifts in the tenor of the housing policy debate, and in some features of recent housing legislation, suggest that we may now be on the threshold of a third phase of housing policy. There are two key aspects to this rethinking: The first is the need to return to "first principles" regarding the justification for government involvement in housing assistance for the poor. The focus has been lost or diluted over time as emphasis on causes was replaced by emphasis on symptoms. Second, there is increasing recognition that housing policy alone, as it has been narrowly defined over the last 40 years solely in terms of "bricks and mortar," is simply inadequate to meet the fundamental goals of most social welfare policy, namely, assisting the nation's citizens to reach their maximum potential. For various population groups—the elderly, the handicapped, and vulnerable families with children—housing policy is increasingly emphasizing the goal of independence. Few would argue that this goal can only be achieved if it is explicitly shared by the housing, health, and related sectors, and if policies in these different arenas are consistent. Both of these new directions will also require closer coordination between housing interests and other spheres including, prominently, the health sector.

Housing Policies and Home-Based Care

Housing policy can influence home-based care in at least three ways:

1. through the design of *financing mechanisms* for housing subsidy programs that discourage, tolerate, or support the provision of home-based assistance
2. through *regulations* and *statutes* that either encourage or discourage home-based care
3. through statutory and regulatory provisions, as well as informal mores, that facilitate or obstruct the *coordination* of housing policy and programs with those in the health care arena

Financing

Housing subsidy programs are directed mainly toward rental housing. More than four million rental housing units in the nation are part of the federally assisted or subsidized housing inventory. Assistance takes one of two forms: supply-side (or “project-based”) subsidies, which underwrite housing development, and in some cases operating costs; and demand-side (or “tenant-based”) subsidies, which provide assistance to the tenant recipient in the form of a rent write-down. Each of these two generic types of assistance has taken numerous forms over the roughly 60-year history of assisted housing policy. All of these designs focused solely on financing physical structures or rental payments; supporting home-based care was never a consideration. Throughout all of these variations, however, there is little to suggest that the inherent design of any of these housing subsidy financing schemes has either encouraged or discouraged home-based care. Their effects appear to be neutral.

One general feature of current domestic policy fragmentation, however, has proved to be problematic to housing providers attempting to serve tenants who need both housing and supportive services. Essentially all housing subsidy programs—be they for supply or demand—represent multiyear commitments of federal revenues. Development subsidies typically commit a stream of funding over 20, 30, or even 40 years, whereas tenant subsidies have generally extended to 15 years, a term recently reduced to five, with the possibility of renewal. In almost all cases, home and community-based services are funded annually, introducing the element of risk of funding loss that does not exist with federally guaran-

teed, multiyear housing subsidies. This inconsistency in funding terms has discouraged developers with an interest in providing housing for individuals who need supportive services from acting on that interest.

Perhaps surprisingly for some, there are a number of ways in which the financing of assisted housing actually encourages home and community-based care. As noted earlier, federal housing policy has begun to recognize the legitimacy of broadening its scope beyond traditional housing boundaries. Although the Department of Housing and Urban Development (HUD) is a housing, not a service, agency, a growing body of convincing evidence indicates that the ability of some individuals to maintain—and retain—housing is closely connected to, and in some cases determined by, availability of appropriate services. This has led to the somewhat ironic conclusion that a key *housing* policy issue is ensuring that the service needs of residents are being met (Newman 1992). The evolution in the definition and boundaries of housing policy is reflected in various features of a number of housing programs, including their financial structure, a topic that is reviewed in the next section. Because the connection between housing policy and home-based care is embodied in programs designed for two population groups—the frail elderly and disabled persons, some proportion of whom are homeless—this review treats separately the programs that address each of these groups. Key features of each program are summarized in the Appendix.

The Frail Elderly. Supply-Side Programs. Four supply-side programs that serve the frail elderly have funding mechanisms designed in part to facilitate service access and utilization. Section 202 requires the design of subsidized developments to permit the provision of services. To meet this requirement, properties must be barrier free, and developers are able to use a portion of their subsidy to provide common rooms, such as dining areas for congregate meals, recreation rooms, and offices. Under recent legislation, a predetermined proportion of the subsidies received from HUD can now also be used to cover the cost of a service coordinator whose primary role is to link the frail elderly tenant to needed supportive services that are available in the community. A similar service coordinator funding provision has also been extended to other housing programs, including public housing and other supply-side programs that have served the frail elderly. The fourth program represents the most significant acknowledgment of the frail elderly's need for supportive housing, although it is stronger in concept than in numbers of persons assisted. Before the 1990 legislation, the only housing program for the elderly

that allowed—and in fact required—the provision of supportive services was the federal Congregate Housing Services Program (CHSP), administered by HUD in urban areas and by the Farmers Home Administration (FmHA) in rural areas. The distinguishing feature of CHSP is that funding for *both* housing and support services comes from HUD or FmHA. CHSP, however, is a very small program that has operated in only about 60 public housing and Section 202 projects, offering housing and support services to 1,800 persons annually. HUD and FmHA recently announced awards to 45 new sites—the first new awards in more than a decade.

The nature of HUD financing under the Section 8 New Construction (NC) and Substantial Rehabilitation (SR) programs suggests that many developments are likely to have sufficient excess income to afford some level of expenditure on services above and beyond any increased funding they may receive from HUD or other sources. This excess income is a direct result of the structuring of their HUD subsidy: by applying an annual adjustment factor (AAF) designed to account for inflation in costs over time, surplus cash accumulates in the project over time.

A major reason for the growth in surplus cash is that the AAF is applied to both the variable costs of operating expenses (utilities, insurance, and the like) and the stable costs of debt service. This issue is one, among many, now being examined by HUD and congressional committees. Obviously, if the AAF is redesigned to apply only to variable operating expenses, the pool of surplus cash will not grow at nearly the same rate as it has historically. Nonetheless, all developments currently in operation were developed and have functioned under the original system so that many have generated at least some level of surplus cash. Thus, if services were recognized by HUD as a legitimate operating expense, it is likely that a significant number of developments could leverage at least some of their surplus cash to cover the cost. Because the relevant regulation currently states that HUD must approve the uses of surplus cash, this recognition would not require a change in HUD regulations, but would require that HUD approve supportive services as an operating cost. (One component of the Robert Wood Johnson Foundation's Support Services in Senior Housing demonstration program has been testing the use of surplus cash to cover service costs.)

In the event that surplus cash is not available, an alternative method that could be pursued to fund supportive services is a liberalization of the "special rent adjustment" (SRA) provision in the Section 8 law. Cur-

rently, SRAs are limited to increased costs for security, insurance, real estate taxes, and utilities that exceed the growth accounted for by the AAF. Congress could expand these categories to include supportive services. It is important to emphasize that the SRA does *not* affect the amount of rent paid by the elderly tenant. This remains at 30 percent of the household's adjusted income.

If HUD gave approval to all private developments, such as Section 8 NC and SR, to use operating reserves for supportive services, a rough order of magnitude of the number of elderly households that would be affected is more than 600,000 (Casey 1992; U.S. Department of Housing and Urban Development 1993).

Demand-Side Programs. In contrast to the long history of, and high participation rates in, supply-side supportive housing sponsored by HUD, accommodating the frail elderly in demand-side programs (Section 8 certificates and vouchers) is only now being explored. As of 1989, the latest year for which data are available, roughly 240,000 elderly-headed households were participating in the certificate and voucher programs, representing 22.5 percent of all participants. A recent analysis suggests that the elderly who use these forms of tenant-based assistance experience a lower incidence of physical housing deficiencies and affordability problems compared with similar elderly who do not receive housing assistance, although there is no difference in the quality of their neighborhoods, in general, or crime, in particular (Newman and Schnare 1993).

Programs like Section 8 certificates and vouchers underwrite a portion of the household's rent in the private market. Because the certificate or voucher does not have to be used in a particular housing development, such as an apartment building occupied exclusively by the elderly, the economies of scale that make it feasible to hire a service coordinator or in-home care staff in congregate housing for the elderly do not exist. The alternative mechanism currently being tested in a HUD demonstration program is to provide the tenant with an "enriched" voucher that can be used for both rental and services costs (including the costs of a case manager who can assemble appropriate services for the client). While HUD will continue to fund 100 percent of the rental subsidy, the cost of the supportive services will be divided among HUD (40 percent), the local public housing authorities (PHAs) that administer federal housing programs (50 percent), and the service recipients (10 percent). A key question that HUD and Congress hope to answer is how the match-

ing funds required of elderly recipients affect the sustainability of the program.

Home Equity Conversion Schemes. Beyond supply-side and demand-side policies aimed at assisting low-income renters, housing legislation passed in the last decade that is directed to elderly *homeowners* is also relevant to the housing-long-term-care nexus. The focus of these legislative provisions is the homeowner who wishes to remain in place but is experiencing cash flow problems. Under Home Equity Conversion Mortgage instruments (HECMs) (e.g., lines of credit, lump sum payments, reverse annuity mortgages), the elderly homeowner can continue to live in the house while drawing down on accumulated equity. Thus, HECMs allow elderly homeowners to generate cash income from their housing while retaining occupancy, and they do not require repayment until some future date. Legislation passed in 1982 helped make HECMs more widely available. In 1989, HUD launched the Equity Conversion Mortgage Insurance Demonstration Program to determine the need and demand among the elderly for this housing finance instrument and to test the effects of providing FHA insurance for HECMs on participation by both the elderly and financial institutions in the mortgage markets. This demonstration program will end in September 1995, at which time Congress will decide whether to make it a full-fledged program.

From their inception, HECM strategies have attracted attention, at least partly because of their significance for concerns about the long-term-care needs of the elderly (Jacobs and Weissert 1984; Jacobs 1985). For many elderly households, including those who are frail and in need of assistance, the most sizable source of accumulated wealth is the home. Yet this wealth is illiquid and inaccessible, leaving the homeowner house rich and cash poor. HECMs allow the elderly to “liquify” their housing wealth so that they can purchase what they need, including long-term-care services.

In spite of this attractive feature of HECMs, the early offerings by financial institutions during the 1980s did not attract many participants. Knowledgeable observers attribute this lack of interest to four factors:

1. the inherent complexity of the structure of most HECM schemes, which make them difficult to explain to consumers
2. an apparently strong bequest motive among the elderly
3. supply-side constraints such as incomplete markets for resale and securitization (Chinloy and Megbolugbe 1994)

4. perhaps most important, the fact that HECMs make financial sense for only a minority of the elderly—those who own their homes, whose house value is high enough to generate a good monthly income stream, and whose current income is low

Data on the number of elderly who fit into these three categories are not readily available, but the published data indicate that only about 10 percent of those who own homes worth \$60,000 or more have incomes below \$10,000, and about 25 percent have incomes below \$20,000 (Newman 1993). Anecdotal reports suggest that interest in HECMs may have increased in the last few years. However, while Congress authorized funding for up to 25,000 insured loans through 1995 under the FHA insurance demonstration, only 5,000 loans have been written since 1989. HUD reports that applications for its FHA insurance program is “slow but steady” (S. Krems, Office of Single-Family Housing HUD 1993: personal communication).

Disabled Individuals and Homeless Individuals. Until passage of the McKinney Act in 1987, the Section 202 housing program was the major federal source of housing assistance that specifically targeted disabled individuals as a group to be served. Yet it appears that few of the disabled have received benefits under this program. Annual counts of participating persons with mental illness, for example, are exceedingly low, reaching a high of 1,741 units in 1988 (Newman 1992). An evaluation of the program’s effectiveness for persons with mental illness conducted in the early 1980s emphasized three primary contributory factors: the paperwork requirements were very burdensome, particularly for the small nonprofit groups that were most likely to develop housing for severely mentally ill (SMI) individuals; the lag time between application for program funds and occupancy of the first unit was far too long, in some cases lasting five years or more; and program rules did not allow the flexibility required to develop and operate a successful housing setting for SMI persons (Macrosystems 1982; Urban Systems Research and Engineering 1983).

Partly in response to these concerns, the 1990 housing legislation redesigned the program. Known as the Section 811 program, the subsidy now takes the form of a non-interest-bearing capital advance plus contracts for rental assistance. Advances need not be repaid as long as the housing remains occupied by the very-low-income population of disabled individuals for whom it was originally intended (e.g., those with AIDS, SMI persons) for at least 40 years.

The nonrepayment feature of the financing is clearly attractive. Among other benefits, it may free up the nonprofit providers to devote more of their time to on-site management and to assisting tenants in need of help. From the perspective of access to home and community-based supportive services, however, one aspect of the program is troubling. Because the 1990 housing legislation allows the use of federal funds to cover service coordinators in Section 202, but not in Section 811, an inequity seems to have been created. It is possible that disabled individuals who continue to live in their Section 202 units would have access to the help of a service coordinator while participants in the new 811 program would not. The rationale for this distinction was the presumption that disabled individuals would rely on state-funded services to meet their needs (D. Harre, Office of Elderly Housing, HUD, August 4, 1993: personal communication). Although developers applying for 811 funds must demonstrate that they will provide supportive services, these services must be funded separately. This separation of housing and service funding could engender the same types of problems encountered in the original Section 202 program that partly motivated the 1990 provision to cover service coordinators. Furthermore, from the perspective of the allocation of federal funds, the effect is unequal treatment, with participants in the new Section 811 program being disadvantaged relative to comparably impaired individuals in the Section 202 program.

The main response of Congress to the housing plus service needs of homeless persons, including those suffering from mental illness, HIV infection, and co-occurring substance abuse, has been the Stewart B. McKinney Homeless Assistance Act, first passed in 1987 and amended in 1988 and 1990 (see Newman 1992). Subsequently, the 1992 housing act, containing features relevant to homeless persons, was passed. The key provisions in both acts are:

1. the Section 8 Moderate Rehabilitation Program for Single-Room Occupancy (SRO) settings, which subsidizes the rehabilitation of SRO units and supportive services provided on site
2. the Supportive Housing Demonstration Program (SHDP), which is a dollar-for-dollar federal/nonfederal matching grant program that, as of 1992, had developed 28,000 transitional and 3,000 permanent housing units
3. the Supportive Housing Program, which replaced SHDP in 1992 and provides matching funds for transitional, permanent, and innovative housing for the homeless as well as supportive services

4. Projects for Assistance in Transition to Homelessness (PATH), which is a formula matching grant to the states to provide supportive services to homeless persons who are also mentally ill
5. the Shelter Plus Care Program, which provides HUD rental assistance that must be matched by supportive services of equivalent value and targets three groups of homeless persons: the severely mentally ill, those with chronic substance abuse problems, and those who have AIDS (see Appendix)

At this writing, the future of these, and other, housing programs is uncertain. According to the Clinton administration's current plan, homeless assistance programs would go through two phases of consolidation (U.S. Department of Housing and Urban Development 1995). Through fiscal year 1996/97, these programs would be consolidated but kept in a separate block grant to give communities time to establish a "continuum of care." In the following fiscal year, the homeless programs block grant would be combined with programs targeting other population groups under a broader umbrella block grant: the Affordable Housing Fund.

Additional Observations on Financing. The recent housing programs acknowledging the "more than just housing" needs of many participants, which preceded the current "reinvention" proposals, represent exceptions—albeit significant exceptions—to the typical financing structure of low-income housing. For all intents and purposes, HUD no longer provides production subsidies for the construction or substantial rehabilitation of multifamily structures (which, as noted earlier, were not designed for home-based care). As a result, developers must piece together bits of financing from multiple sources that in many instances do not even include the mainstream programs just reviewed. Reliance on six or more different capital financing sources is not uncommon (Sandorf 1991). Presumably because of the added effort required, this retail approach to capital financing may provide little leeway for also raising funds for on-site supportive services like home-based care. Unfortunately, we cannot look at past experience to judge whether generating funding for home-based services would be more likely under the kind of production subsidy programs that existed 10 or more years ago. At that time, there was far less sensitivity to the service needs of vulnerable tenant groups and, therefore, little attention to, or documentation of, funding services in project-based subsidized housing. The one clear ex-

ception is the Section 202 program, which unarguably has succeeded in increasing the supply of service-enriched quality housing to frail and disabled low-income groups.

At the more affluent end of the income spectrum, the private sector has targeted senior citizens as a market for “purpose built” projects that fall into three broad categories: independent living, assisted living, and life care. Independent living developments are aimed at healthy, active individuals who are primarily seeking reduced home maintenance burdens, opportunities for social interaction, and the convenience of on-site services, such as meals, recreation, and housekeeping. Assisted living caters to a more frail, less independent elderly population. On-site services may range from meals and housekeeping to assistance with activities of daily living and instrumental activities of daily living, such as bathing, dressing, and taking medications. Life care communities combine features of each of the first two setting types and often add a third, namely, a nursing home located either on the same campus or nearby (Newman and Scanlon 1989). Although the comprehensiveness of services varies across these three settings, the financing principle is the same: residents pay for the services they receive either through the endowment payment they made upon moving in, through their monthly rental or maintenance fee, or on a fee-for-service basis. Industry experts have not yet observed any effects of long-term-care insurance on these markets.

Regulations and Statutes

Housing statutes and their regulatory interpretation set the boundaries of housing policy including, crucially, the boundaries of the “allowable.” The size and physical configuration of dwellings, the adequacy and condition of the housing unit and surrounding neighborhood, and the ability of individuals with varying degrees of functional impairment to reside in housing units located in the community are just some examples of the direct and indirect ways in which housing laws and regulations determine whether those in need have access to home-based care and whether its provision is feasible.

Housing Quality Standards. All housing units must comply with a mix of construction and maintenance standards, commonly called “codes,” that are related to the physical condition of the building and dwelling unit. From a societal perspective, “codes represent the level of conditions

which the public and their representatives consider to be economically, socially, and politically necessary, as well as acceptable and feasible at the time of their adoption" (American Public Health Association 1971). These standards, however, should not be viewed as immutable; new knowledge, demographic shifts, or changing perceptions of desirable housing conditions require that codes be subject to continuous reevaluation.

Building and other *construction codes* are enforced primarily through a system of permits that are granted after plans and detailed specifications for the physical structure have been submitted to, and evaluated by, the relevant local government review board. These government agencies hold the power to issue, or to withhold, the required permits (American Public Health Association 1971). By contrast, *housing codes* establish minimum standards essential to make dwellings safe, sanitary, and fit for human habitation by governing the physical conditions of the property, its maintenance, utilities, and occupancy (American Public Health Association 1971). Although the specific content of codes is left to the discretion of each locality, most rely on a similar set that typically covers minimum room square footage by function, natural light and air, and the state of repair of electric, heating, and plumbing systems.

Knowledgeable observers suggest that whereas building and construction codes are generally well enforced, housing codes are not. In the face of major budget constraints, many cities have had to make deep cuts in services, including code enforcement. Baltimore, for example, has adopted the strategy of inspecting a portion of its multifamily housing stock each year on a rotating basis, and inspecting single-family homes on an "as need" basis only, primarily in response to complaints from occupants and neighbors. Because the modal housing structure type in Baltimore is the rowhouse, this policy means that most dwellings in the city are never inspected for code compliance. Furthermore, follow-up with property owners who have received code citations to assure the completion of proper repairs is also inadequate (Introduction to Policy Analysis Students 1992). One by-product of a spotty housing code compliance and enforcement system in many cities is its effect on home-care workers, as noted by Scharer, Berson, and Brickner (1990): "Unsafe housing is a major problem that confronts providers of home care services."

The federally assisted housing inventory of more than four million rental housing units is governed by a somewhat different system of housing standards and enforcement. All housing units in the assisted inventory must meet a set of housing quality standards, or HQSs, which are similar in content to housing codes. The HQSs cover both maintenance

and structural attributes, including peeling paint, malfunctioning heating, presence of rodents, and absence of complete plumbing. Within the last decade, public housing authorities (PHAs) have been given the option of substituting their local housing codes for the HUD HQSs, but they are not allowed to rely on their locality's mechanism for code enforcement. Instead, every unit in the subsidized inventory must be inspected once a year by a trained HUD housing inspector. A schedule of reinspections is established for units that fail. Despite these requirements, studies conducted by the HUD Office of the Inspector General have found a substantial error rate in the application of the HQSs, the most worrisome of which is what statisticians refer to as Type I errors; that is, dwelling units that are deemed physically adequate when they actually are not (*Housing and Development Reporter* 1989).

Housing codes, the HQSs, and their enforcement are likely to have indirect effects on the delivery of home-based care. Several plausible scenarios of how this may occur were advanced at the outset of this article. Inadequate codes or, more important, inadequate enforcement of existing codes may perpetuate substandard housing, thereby obstructing or preventing home-based care from being delivered. Individuals in need of home-based care services may, in turn, be denied access to these services (Scharer, Berson, and Brickner 1990).

Neighborhood Conditions. Unlike housing codes, which pertain to dwelling units in both the private and assisted inventory, explicit site and neighborhood standards apply to the assisted stock only and, within the assisted stock, to units receiving project-based assistance only. The main instruments for neighborhood standards in the private market are a combination of local zoning regulations and law enforcement, which, by and large, fall outside the boundaries of housing policy per se. The assisted stock is, of course, subject to these same mechanisms, but the *Code of Federal Regulations* lists additional requirements, such as the following:

The neighborhood must not be one which is seriously detrimental to family life or in which substandard dwellings or other undesirable elements predominate, unless there is actively in progress a concerted program to remedy the undesirable conditions; . . .

The housing must be accessible to social, recreational, educational, commercial, and health facilities and services, and other municipal facilities and services that are at least equivalent to those typically found in neighborhoods consisting largely of unassisted, standard housing of similar market rents.¹

¹24 CFR, ch. 7. §§ 880.206, 885.730 (1990).

Both of these standards clearly apply to the delivery of home-based care. The first, which may also fall within the jurisdiction of local zoning regulations and law enforcement, attempts to address neighborhood conditions, such as lack of safety, which can deter providers of home-based care services. According to Scharer, Berson, and Brickner (1990), some providers have arranged with security services for escorts to accompany home care workers visiting unsafe neighborhoods. Maintaining 24-hour, on-call services is much more difficult under these circumstances and often means that residents living in these areas who need in-home care may be denied access to needed services. The second standard raises the issue of accessibility to health facilities and services, including community-based services.

It is not possible to assess how well zoning regulations and local law enforcement promote and preserve safety in the tens of thousands of neighborhoods across the nation. This is a question best addressed by each locality. Recent research (Newman and Schnare 1993) raises concerns about how well some assisted housing programs meet their site and neighborhood standards: households with children living in public housing gave low ratings to the quality of their neighborhoods, with 37 percent reporting crime to be a significant problem. However, residence in public housing was not significantly associated with low neighborhood ratings for other households, namely, the elderly and nonelderly individuals without children, the majority of whom are disabled; the fractions of each group reporting crime to be a problem were 10 percent and 11 percent, respectively. Because most individuals in the latter two groups reside in separate public housing developments that explicitly target the elderly and handicapped, there may be a dichotomy in the way site and neighborhood standards are applied to public housing for different household types.

Legislative and Regulatory Changes. Over the nearly 60-year history of national housing policy, legislative and regulatory changes have either facilitated, or obstructed, the link between housing and home-based care. Examples of how links were facilitated appeared in the previous section, including several new provisions enabled by the 1990 housing act, the Housing and Community Development Act of 1992, and the McKinney Act. By and large, these programs represent serious efforts to support the links. Examples of obstacles to linkage also exist, perhaps the most dramatic being the 1981 changes in regulations governing the Section 202 program.

In an effort to reduce the production levels and costs of the Section

202 program, the Reagan administration introduced a number of cost containment requirements:

1. Twenty-five percent of units in each project must be efficiencies.
2. Unit sizes for efficiencies must be limited to 415 square feet.
3. The total cost of space not attributable to dwelling use cannot exceed 10 percent of total project cost.
4. Amenities and design features are restricted.

An analysis of the impact of these measures concluded that they may have undermined the "ability of Section 202 projects to meet the special needs of elderly tenants," including the frail elderly who are a key target group for the program (Turner 1985). It is hard to imagine that an efficiency unit of 415 square feet could accommodate a caregiver who may be required to stay overnight, and even daily home-based care visits may raise logistical problems. Limitations on common areas also raise serious concerns. Turner found that, in the sample of HUD field offices she studied, these restrictions had the effect of eliminating congregate dining rooms altogether. Here again, eliminating the option of congregate meals would appear to disadvantage the very target group of frail elderly who were the intended beneficiaries of the program. Indeed, the 1981 cost containment regulations may have discouraged frail elderly from applying to the program in the short run and required Section 202 residents who became frail to move out over the longer run. If that move was to a nursing home, the attempt to save money was clearly ill conceived.

Residency Requirements. Historically, another way in which housing policy has indirectly affected the demand for, and utilization of, home-based care is through tenant admission and retention policies. If housing developments are able to exclude individuals with disabilities or to ask tenants to leave should they become disabled, the contours of the market for home and community-based care will obviously be affected. One possible outcome is that more individuals in need of care will move, either in with relatives or to a setting that offers more intensive services than required. Although, as described in the next section, the Fair Housing Amendments Act and the Americans with Disabilities Act are designed to attenuate these effects, such effects have not been eliminated entirely.

Research on admission and retention policies in housing for the elderly suggests that such policies are generally ad hoc and inconsistent (Bernstein 1982). In a study of 116 HUD-subsidized housing projects

for the elderly, Bernstein found that nearly equal proportions could be characterized as having policies that were "strict" and "not strict." Most developments accepted the reality of sensory changes, onset of chronic conditions, and mobility problems among many of their elderly tenants who age in place. Property owners and managers also agreed to having these problems addressed through links with home and community-based services, such as home-delivered meals, housekeeping, and visiting nurses. On the other hand, certain health conditions raised more problems for admission and retention, partly, according to Bernstein, because these impairments are "the least amenable to help via traditional community services" (p. 312). Included here are serious emotional and mental problems, substance abuse, accident proneness, and reclusive behavior. One of the basic goals of recent fair housing and disability rights legislation is to take all feasible steps to accommodate individuals with a broader range of disabling conditions, including some of those just noted, in housing in the community.

The Fair Housing Amendments Act of 1988 and the Americans with Disabilities Act of 1990. The Fair Housing Amendments Act of 1988 (FHAA) and the Americans with Disabilities Act (ADA) of 1990 are two significant pieces of legislation for individuals with functional impairments and disabilities, including the frail elderly and persons with mental or physical handicaps. Although the ADA addresses a wide range of civil rights, and thus is not limited to a single issue, its housing provisions nevertheless supplement and reinforce those of the FHAA (Milstein and Hitov 1993). Both also strongly support a link between housing and home-based care.

Until passage of these statutes, physically or mentally impaired individuals were excluded from explicit coverage by the housing discrimination provisions of the Civil Rights Act of 1968, which pertain to the sale or rental of a dwelling. As a result, landlords, owners, and management companies could use subjective and ad hoc criteria to reject applications from impaired individuals for renting or purchasing property or, in the case of rental dwellings, for renewing leases. The FHAA and ADA now prohibit such exclusion or lease termination. The only health-related basis for exclusion is the determination that the prospective buyers or tenants will pose a direct threat to the health and safety of others. This determination is to be based solely on the applicant's past behavior as a housing resident; landlords and sellers cannot probe into underlying medical conditions and cannot ask different questions of a person perceived as having a disability. Thus, in the case of an elderly tenant appli-

cant in the early stages of Alzheimer's disease, for example, landlords cannot speculate about possible future problems as a basis for denying tenancy. However, landlords are allowed to ask whether the tenant applicant qualifies for a dwelling that is only available to the handicapped. This type of inquiry is allowed because it appears to be the only way to determine whether the tenant is eligible for special government housing programs for the handicapped (Newman and Mezrich, forthcoming).

A second key way in which these statutes support the link between housing and home-based care is by requiring owners to make reasonable modifications and accommodations that will enable a handicapped or impaired individual to live in the dwelling. Under the FHAA, "modifications" can include not only the individual's own dwelling but also common interior or exterior areas. Examples cited in the FHAA regulations include installation of grab bars in the bathroom, which may also require proper reinforcement of the walls, and the widening of passage doorways into, and within, the dwelling. "Accommodations" pertain mainly to adjustments in rules, policies, practices, or services. Examples of accommodations include permitting a seeing-eye dog to live with a blind individual in a building that doesn't allow pets and assigning to a mobility-impaired tenant a parking space adjacent to the main entrance in a building that does not assign parking spaces for other tenants. The ADA takes the modifications and accommodations provisions even further. In cases where undue financial and administrative burdens would exempt the owner from having to make the dwelling structurally accessible as required by the FHAA, the ADA regulations suggest additional alternatives that may achieve accessibility, including assigning aides to tenants, and arranging for home visits (Milstein and Hitov 1993). Thus, the FHAA and ADA have both indirect and direct effects on home-based care. The indirect effects are connoted by provisions that enable disabled individuals to reside in housing in the community at large, thereby creating or sustaining the market for home and community-based care. The direct effects are embodied in the ADA regulations that specifically cite home-based care as an approach to meet the needs of impaired residents.

Coordination

The feasibility of home-based care is arguably greater if housing and health policy makers, as well as those in the frontlines of housing and health service delivery, coordinate their efforts (see Pynoos 1990; Red-

foot and Sloan 1991). This is particularly likely to be the case in assisted projects housing large numbers of individuals with home-based care needs. By and large, however, formal and informal signals from both the housing and health sectors have discouraged cooperation and coordination.

On a structural level, the design and funding of housing and health legislation and the implementation of housing and health programs are the responsibility of different congressional or legislative committees and governmental agencies. One observer believes that the current system compartmentalizes specific parts of underlying problems, making it almost impossible to fashion an integrated and coherent response (Walker 1990). Furthermore, local agencies vested with administrative and fiscal oversight of housing and health policy have inconsistent geographic boundaries. Health matters typically are under the jurisdiction of single agencies within the state and local governments. Although all states have a state housing agency, the primary focus of these departments has traditionally been *state* housing programs; federal housing programs are largely controlled by local public housing authorities that operate quite independently of state and local government (Council of State Community Development Agencies and American Public Welfare Association 1993). Substantively, health and housing professionals and policy makers have different orientations and types of expertise. It is rare to find individuals knowledgeable in both areas, as the short list of research on housing and home-based care reviewed at the outset of this article demonstrates.

Funding is also a barrier to cooperation for at least three reasons. First, as noted earlier, health and housing programs differ in the time commitments of funding streams; housing programs offer multiyear commitments, whereas health programs represent annual appropriations. Additionally, a significant share of health programs are entitlements to all who are income eligible; housing assistance is not an entitlement. Instead, it is allocated first to specially designated preference groups like the homeless, and second, on a first come–first served basis, to other income-eligible households. One result of the different eligibility rules for housing and health programs is that many more income-eligible households do not receive housing assistance than do. Finally, during times of fiscal austerity, all levels of government are typically less willing to launch new initiatives such as those required to foster coordination. Some observers have correlated the budget pressures of the last decade with the hardening of agency boundaries and a particularly vigorous effort to protect turf (Council of State Community Development Agencies and American Public Welfare Association 1993). Agencies may also be

prohibited by regulations to use program funding to underwrite coordination activities.

Despite these barriers, the catalyst of homelessness has resulted in various steps toward coordination during the last decade. Among the more important initiatives introduced during this time were the following: (a) a Memorandum of Understanding between HUD and HHS, which reduced the bureaucratic red tape preventing the two staffs from working together; (b) the federal Interagency Task Force on Homelessness, emulated by numerous task forces in many states; (c) passage of the McKinney Act, the 1990 National Affordable Housing Act, and the Housing and Community Development Act of 1992, each of which enables the formation of housing programs that *require* coordination with partners from other fields including, prominently, health and human services experts. For example, every state must submit a Comprehensive Housing Affordability Strategy (CHAS) in order to be eligible for funding from most housing and community development programs. Because the CHAS requires information on a broad range of topics pertaining to living conditions, poverty, and quality of life, preparing the CHAS required interagency collaboration. Another example is the Shelter Plus Care Program discussed earlier. In this competitive grant program, significantly higher points are awarded to applicants who have developed their plans in coordination with other agencies serving homeless people, and to applications that include *commitments* to provide supportive services.

Some private foundations have also been catalysts for coordinating programs and funding to assist the homeless. In the 1980s, for example, the Robert Wood Johnson Foundation launched two demonstration programs: the Program on Chronic Mental Illness and the Homeless Families Program. In both cases, a Memorandum of Understanding was developed between the public housing authority and the service agencies and, with funding from HUD, Section 8 certificates were provided to individuals linked to supportive services, primarily case management.

Another population group that has generated coordination between housing and health services is the frail elderly. The Congregate Housing Services Program and the service coordinator subsidies for Section 202 and public housing for the elderly have already been discussed. Another clear example is the Supportive Services in Senior Housing demonstration program, mentioned earlier, that is funded by the Robert Wood Johnson Foundation. A key component of this demonstration has been delegated to state housing finance agencies (HFAs) "to build and institutionalize a service responsibility within the HFA" (Feder, Scanlon, and

Howard 1992). Under the demonstration, participating housing developments for the elderly have hired service coordinators using funds from the operating budgets or reserves of the individual developments and from the HFA.

Whether these initial steps toward coordination will have lasting positive impacts on recipients depends on one's interpretation. A pessimistic view would emphasize that, upon closer examination, many of the housing programs that have been initiated neglect coordination, emphasizing instead expansion of the housing system in order to add services for its clientele. From a broad policy perspective, having the housing system take on the added responsibility of the supportive service system does little to improve efficiency. Yet the newness of the recognition of a broader set of needs and of attempts to meet them suggests a wholly different and more optimistic interpretation. Just as the needs to be met by the health and housing systems have changed over time, so, too, must the strategies adapt to these needs. Both systems are at an early stage of exploring and testing strategies. Informal arrangements constitute one possible approach; another would be to broaden the mission of each system and attempt to bridge them more formally. As a first step, for example, the housing and health systems need to become better acquainted with each other and more aware of the ways in which the interrelationship between health and housing can affect their clientele. One way to accomplish these objectives is through statewide or local task forces that include members of both systems who are developing strategies to address a shared problem, such as homelessness or the lack of sufficient, affordable, service-enriched housing. Such strategies have the advantage of providing each system with a much better understanding of the other's mission and expertise. Whether the ultimate outcome will be true coordination and cooperation only time will tell.

Conclusions

A key message of this review is that, particularly over the past five years, housing policy in the United States has taken a number of significant steps toward accommodating the special needs of some population groups, including the need for home-based assistance. Some prominent examples include the Shelter Plus Care Program, which requires sponsors to match the housing subsidies they receive from HUD with services of

equal value; the Section 202 program and public housing for the elderly, which allow use of a portion of HUD funding to hire a service coordinator; and the combination of the FHAA and the ADA, both of which require landlords to make reasonable modifications and accommodations so that persons with disabilities may live in housing units in the community. Taken together, this body of policy suggests a broadened definition of the fundamental goals of housing policy as stated in the 1949 housing act: "a decent home and suitable living environment."

Most of these programs are now in flux. The Clinton administration has proposed to consolidate most of the major housing programs into three block grants. A number of programs for the elderly, the disabled, the homeless, and the general population of income-eligible households would be folded into a single Affordable Housing Fund. Because the proposal does not place priority on assisting particular target groups, some observers believe that localities may be inclined to use the funds for "historically favored" populations, like the elderly and the working poor, at the expense of the homeless, persons with disabilities, and welfare recipients (*Housing and Development Reporter* 1994).

Yet, even before the administration proposed radical alterations of HUD housing assistance programs, some questioned whether the strides made by HUD set a trend for the future or were an idiosyncratic blip. In his review of the 1990 housing act, Pynoos (1992) described the alignment of research, policy, and politics that allowed the act to pass as "akin to a total eclipse of the sun." Furthermore, the fact that housing programs are not entitlements means that most of the initiatives reviewed will affect only a small fraction of those in need. Thus, a major challenge for future policies is closing the many gaps that remain. Among the most important are those pertaining to the physical adequacy and safety of housing units and neighborhoods. Focusing on these two fundamental objectives has the dual advantage of affecting the greatest number of households while not relying solely on the vagaries of congressional actions regarding HUD programs.

Although virtually all communities across the nation have adopted a set of local housing codes that are designed to assure the adequacy and safety of dwelling units in each jurisdiction, the existence of these codes is of little consequence if they are not vigorously and comprehensively enforced. To the extent that the main deterrent to enforcement is lack of resources, the solution is straightforward though, in times of fiscal restraint, politically unpopular. One approach is to increase the amount of money each community receives under the Community Development

Block Grant, with the hope that these resources would be spent on code enforcement. Some communities, however, may require additional encouragement to target resources in this way. In these instances, a special code enforcement program may be required, one similar to the concentrated code enforcement programs that existed in the early 1970s.

Although communities also have local law enforcement systems in place to address the most troubling neighborhood problem—safety—experience to date suggests that the nature and extent of the problem makes it very difficult to deal with in many localities. Here, too, insufficient resources are likely to play a role and are a prime target of President Clinton's proposed Anti-Crime Bill, which would support 50,000 additional police officers around the country. An even more fundamental problem is uncertainty regarding the most effective strategies for preventing neighborhood crime. A number of approaches are being tried, such as voluntary neighborhood watch teams and the reintroduction of community policing and neighborhood beat patrols. Incentives for continuous experimentation with multiple approaches are warranted.

Another important gap is not in policies or programs, but in knowledge. Little systematic research has been done on the relationship between housing and neighborhood conditions and home-based care. As a result, we lack objective information about specific environmental features that affect home-based care access, delivery, quality, and cost. It is unfortunate that past evaluations of home-based care initiatives, including both the numerous demonstrations conducted in the 1970s and the major Channeling demonstration, did not address housing issues. Any future demonstrations should not repeat this mistake. The idea of adding a housing supplement to ongoing data collections relevant to health and long-term care, such as the National Health Interview Survey and the National Long-Term Care Survey, should also be explored (Newman, forthcoming). And ongoing programs may be ripe for careful evaluations of the role of housing. Beyond offering a better understanding of the part that housing plays in home-based care, such studies can provide hard evidence on what works, for whom, and under what circumstances—precisely the type of information that is now lacking for use in informed policy decisions.

The value of solid research notwithstanding, Redfoot and Sloan point out, in their legislative history of the Congregate Housing Services Program, that research and logic may ultimately have little to do with the successful passage of a program because of “powerful jurisdictional and

institutional barriers” (Redfoot and Sloan 1991). This brings us to the final gap—the lack of a well-developed, formal system that fosters ongoing coordination between the housing and health policy and practice arenas. Here, again, various strides have recently been made to forge connections between these systems. What is now needed is an overarching policy framework that ties the two systems together, where appropriate, to ensure that *both* the housing and home-based-care needs of the individual are being met. There are various approaches to achieving this coordinated system. A radical approach would be to rebuild a new integrated system essentially from the ground up. A more modest, and realistic, approach would be to reshape the existing collection of programs into a more coherent and effective system. The core objective of this reshaping would be to remove the legal and institutional barriers that have kept the two systems apart. Although a detailed analysis of alternative models of coordination is beyond the scope of this article, recent work on the human resource investment system (e.g., job training, welfare-to-work) suggests several strategies (e.g., Employment and Training Administration 1991; National Governors’ Association 1993). Among the “top down” strategies that are either encouraged or imposed by the federal or state government are the following:

1. requiring each state to create an integrated plan that establishes goals, objective, and outcome expectations for each of the programs in the coordinated system
2. ensuring that innovators will not be worse off for attempting to coordinate
3. increasing flexibility in using funds to coordinate
4. developing and requiring all programs to use uniform terms and definitions
5. standardizing the fiscal and administrative procedures across programs

“Bottom up” strategies that are locally developed include:

1. special boards to oversee all relevant programs at the local level and to approve or disapprove local plans for federal and state funds (similar to the CHAS for housing and community development subsidies)
2. “one-stop shopping,” where individuals in need of either housing assistance, home-based care assistance, or some combination of the

- two would face a single point of entry, eligibility determination, assessment, referral, and perhaps service delivery
3. integrated management information systems
 4. co-location of staff from the different systems in the same building

The informal efforts to coordinate the housing and health systems that have occurred in a number of communities, even in environments where neither system has encouraged it, have required two characteristics—flexibility and a willingness to change—on the part of each system. It is perhaps these same characteristics that will ultimately determine the success of efforts to formalize coordination and assure its continuity.

References

- American Public Health Association. 1971. *Housing: Basic Health Principles and Recommended Ordinance*. Washington.
- Berkeley Planning Associates. 1985. *Evaluation of Coordinated Community-Oriented Long-Term Care Demonstration Projects: Final Report*. Berkeley, Calif.
- Bernstein, J. 1982. Who Leaves—Who Stays: Residency Policy in Housing for the Elderly. *Gerontologist* 22:305–13.
- Casey, C. 1992. *Characteristics of HUD-Assisted Renters and Their Units in 1989*. Washington: U.S. Department of Housing and Urban Development, Office of Policy Development and Research.
- Chinloy, P., and I. Megbolugbe. 1994. Reverse Mortgages: Contracting and Crossover Risk. *Journal of the American Real Estate and Urban Economics Association* 22:367–86.
- Council of State Community Development Agencies and American Public Welfare Association. 1993. Excerpts from Interim Final Report to the Ford Foundation on Implementing Housing and Human Service Collaboration. Washington.
- Employment and Training Administration. 1991. *An Assessment of the JTPA Role in State and Local Coordination Activities*. Washington: U.S. Department of Labor.
- Eustis, N., R. Kane, and L. Fischer. 1993. Home Care Quality and the Home Care Worker: Beyond Quality Assurance as Usual. *Gerontologist* 33:64–73.
- Feder, J., W. Scanlon, and J. Howard. 1992. Supportive Services in Senior Housing: Preliminary Evidence on Feasibility and Impact. *Generations* (spring):61–2.

- Housing and Development Reporter*. 1989. Problems in Single Family, Voucher, Other Programs Noted in OIG Report. 17(6):114.
- . 1994. Tenants Would Fare Poorly under Block Grants, NHP Says. 22(36):552-3.
- Introduction to Public Analysis Students. 1992. Housing Problems Facing Baltimore. Baltimore: Johns Hopkins University, Institute for Policy Studies. (mimeo)
- Jacobs, B. 1985. A Note on Recent Analyses of the Potential for Using Home Equity to Help Finance Long-Term Care for the Elderly (discussion paper no. 8503). Rochester, N.Y.: University of Rochester Public Policy Analysis Program. (mimeo)
- Jacobs, B., and W. Weissert. 1984. Home Equity Financing of Long-Term Care for the Elderly (discussion paper no. 8401). Rochester, N.Y.: University of Rochester Public Policy Analysis Program. (mimeo)
- Macrosystems. 1982. *Exploratory Evaluation of the HUD-HHS Demonstration Program for Deinstitutionalization of the Chronically Mentally Ill: Final Report*. Washington. (mimeo)
- Mathematica Policy Research. 1987. *The Evaluation of the National Long Term Care Demonstration: Final Report*. Princeton, N.J.
- Milstein, B., and S. Hitov. 1993. Housing and the ADA. In *Implementing the Americans with Disabilities Act: Rights and Responsibilities of All Americans*, eds. L. Gostin and H. Beyer. Baltimore: Paul H. Brookes.
- Mindel, C., R. Wright Jr., and M. Rice. 1986. Informal and Formal Social Support Systems of Black and White Rural Elderly: A Comparative Cost Approach. *Gerontologist* 26:279-85.
- National Governors' Association. 1993. *Bringing Down the Barriers*. Washington.
- Newman, S. 1985. Housing and Long-Term Care: The Suitability of the Elderly's Housing to the Provision of In-Home Services. *Gerontologist* 25:35-40.
- . 1992. *The Severely Mentally Ill Homeless: Housing Needs and Housing Policy* (occasional paper no. 12). Baltimore: Johns Hopkins University Institute for Policy Studies.
- . 1993. Comment on "Long-Term Care Reform and the Role of Housing Finance." *Housing Policy Debate* 4:551-64.
- . Forthcoming. The Effects of Supports on Sustaining Older Disabled Persons in the Community. *Issue Brief*. Washington: American Association of Retired Persons, Public Policy Institute.
- Newman, S., and M. Mezrich. Forthcoming. Implications of the 1988 Fair Housing Act for the Frail Elderly. In *Staying Put: Adapting the Places Instead of the People*, eds. S. Lansperry and J. Hyde. Amityville, N.Y.: Baywood.

- Newman, S., and W. Scanlon. 1989. Delivery of Long-Term Care Services: New Developments in Nursing Homes and Housing. Paper prepared for UCLA-FHP Foundation meeting, "The Economics and Politics of Long-Term Care," Irvine, Calif., October 11-13.
- Newman, S., J.D. Reschovsky, K. Kaneda, and A. Hendrick. 1994. The Effects of Independent Living on Persons with Chronic Mental Illnesses: An Assessment of the Section 8 Certificate Program. *Milbank Quarterly* 72:171-98.
- Newman, S., and A. Schnare. 1993. Last in Line: Housing Assistance for Households with Children. *Housing Policy Debate* 4:417-55.
- Newman, S., R. Struyk, P. Wright, and M. Rice. 1990. Overwhelming Odds: Caregiving and the Risk of Institutionalization. *Journal of Gerontology* 45(5):S173-S183.
- Noelker, L. 1982. The Impact of Environmental Problems on Caring for Impaired Elders in a Home Setting. Paper presented at the 35th Annual Gerontological Society Meetings, November.
- Noelker, L., and D. Bass. 1989. Home Care for Elderly Persons: Linkage between Formal and Informal Caregivers. *Journal of Gerontology* 44(2):S63-S70.
- Pynoos, J. 1990. Public Policy and Aging in Place: Identifying the Problems and Potential Solutions. In *Aging in Place: Supporting the Frail Elderly in Residential Environments*, ed. D. Tilson. Glenview, Ill.: Scott, Foresman.
- . 1992. Linking Federally Assisted Housing with Services for Frail Older Persons. *Journal of Aging and Social Policy* 4:157-7.
- Pynoos, J., E. Cohen, L. Davis, and S. Bernhardt. 1987. Home Modifications: Improvements that Extend Independence. In *Housing the Aged: Design Directives and Policy Considerations*, eds. V. Regnier and J. Pynoos. New York: Elsevier.
- Redfoot, D., and K. Sloan. 1991. Realities of Political Decision-Making on Congregate Housing. In *Congregate Housing for the Elderly: Theoretical, Policy, and Programmatic Perspectives*, eds. L. Kaye and A. Monk. New York: Haworth Press.
- Sandorf, J. 1991. *Supported Housing Alternatives Project: Final Report and Program Recommendations*. New York.
- Sangl, G. 1983. The Family Support System of the Elderly. In *Long-term Care*, eds. R. Voegel and H. Palmer. Washington: Health Care Financing Administration.
- Scharer, L., A. Berson, and P. Brickner. 1990. Lack of Housing and Its Impact on Human Health: A Service Perspective. *Bulletin of the New York Academy of Medicine* 66:515-25.
- Steinfeld, E. 1975. *Barrier-Free Design for the Elderly and the Disabled*. Syracuse, N.Y.: Syracuse University.

- Struyk, R., and H. Katsura. 1988. *Aging at Home: How the Elderly Adjust Their Housing Without Moving*. New York: Haworth Press.
- Struyk, R., and J.P. Zais. 1982. *Providing Special Dwelling Features for the Elderly with Health and Mobility Problems*. Washington: Urban Institute.
- Sussman, M. 1979. *Social and Economic Supports and Family Environments for the Elderly* (grant report no. 90-A-316[03]). Washington: Administration on Aging.
- Tennstedt, S., and J. McKinlay. 1987. Frail Older People Reliant on Formal Services: Comparison with Those Receiving Informal Care. Presented at the 40th Annual Meeting of the Gerontological Society of America, Washington, D.C., November.
- Thomas, S. 1983. The Significance of Housing as a Resource. In *Long-Term Care*, eds. R. Vogel and H. Palmer. Washington: Health Care Financing Administration.
- Turner, M. 1985. Building Housing for the Low-Income Elderly: Cost Containment in the Section 202 Program. *Gerontologist* 25:271-7.
- Urban Systems Research and Engineering. 1983. *Standards and Criteria for Housing for the CMI in the Section 202/8 Direct Loan Program: Final Report*. Cambridge, Mass. (mimeo)
- U.S. Department of Housing and Urban Development. 1993. *HUD 1994 Budget: Summary Document*. Washington.
- . 1995. *HUD Reinvention: From Blueprint to Action*. Washington.
- Walker, B. 1990. Housing and Health. *Bulletin of the New York Academy of Medicine* 66:382-90.
- Wan, T. 1987. Functionally Disabled Elderly: Health Status, Social Support, and Use of Health Services. *Research on Aging* 9:61-79.
- Weicher, J. 1980. *Housing: Federal Policies and Programs*. Washington: American Enterprise Institute, Studies in Economic Policy.

Acknowledgments: This article was prepared for the Visiting Nurse Service of New York/Milbank Memorial Fund project, "Home-Based Care for a New Century." The author gratefully acknowledges the helpful assistance of Eugene Fogel, David Harre, Pauline Magette, and Jean Whaley at the U.S. Department of Housing and Urban Development, Burt Barnow, Anne Hendrick, and Sally Katz at Johns Hopkins, Jack Kerry of the Kerry Company, and anonymous reviewers.

Address correspondence to: Sandra J. Newman, PhD, Johns Hopkins University, Institute for Policy Studies, Wyman Building, 3400 North Charles Street, Baltimore, MD 21218-2696.

Appendix

Key Features of Housing Policies and Programs Relevant to Home and Community-Based Care

Program	Target group(s) ^a	Key features	Estimated number of participants ^b	Status
1. Section 202 Program for the Elderly (and Handicapped)	Persons 62 years of age or older Persons with mental or physical handicaps eligible until 1990 passage of Section 811 (see below)	Subsidy for property development and operating costs Barrier-free design Provision of common rooms Use of 15% of subsidy for service coordinator	286,172 units as of 1991	Ongoing
2. Congregate Housing Services Program	Frail persons 62 years of age or older	Subsidy for tenant rents and on-site services	c. 1,800	Ongoing
3. Public housing	Families Persons 62 years or older Single disabled persons	Government underwrites full construction costs Formula-driven subsidy for operating costs Subsidized rents	c. 517,000 elderly and handicapped c. 843,000 families	Essentially no new public housing development, but subsidies ongoing to existing properties
4. Section 8 New Construction; Section 8 Substantial Rehabilitation; Section 236; Section 221(d)3	Families Persons 62 years of age or older Single disabled persons	Deep subsidies for property development that have the effect of lowering rents	c. 600,000	Program discontinued, but subsidies ongoing for length of contract

5. Section 8 certificates and vouchers	Families Persons 62 years of age or older Single disabled persons	Rental subsidy that limits tenant rent to 30% of income Dwelling must meet housing quality standards Subsidy amount limited by fair market rent ceiling Units rented from private market	c. 243,800 elderly and handicapped c. 816,200 families	Ongoing: certificates and vouchers combined into one program
6. HOPE for Elderly Independence	Frail persons 62 years of age or older	Subsidy for both rent and services Rental subsidy similar to Section 8 certificates and vouchers	c. 1,447	Five-year demonstration program (1993-98)
7. Reverse annuity mortgages	Homeowners 62 years of age or older	Allows homeowners to cash out the value of their house while retaining occupancy FHA insurance	c. 5,000 (FHA insurance program)	Ongoing
8. Section 811 Housing for Persons with Disabilities Program	Persons <62 years old with mental or physical disabilities	Subsidy for property development and operating costs	c. 4,000 as of 1992	Ongoing
9. Section 8 Moderate Rehabilitation Program for SROs	Homeless persons	Subsidy for rehabilitation of property, tenant rents, and supportive services	c. 7,900 as of 1992	Ongoing
10. Supportive Housing Demonstration Program	Homeless persons	Transitional housing with limit of 24 months on length of stay Permanent housing Nonfederal match required	c. 28,500 as of 1992 c. 3,300 as of 1992	Program discontinued, but subsidies ongoing for length of subsidy term

continued

Appendix continued

Program	Target group(s) ^a	Key features	Estimated number of participants ^b	Status
11. Supportive Housing Program	Homeless persons	Transitional housing Permanent housing Innovative housing Supportive services	Awards not made yet	Ongoing
12. Projects for Assistance in Transition from Homeless Program (PATH)	Persons who are homeless and severely mentally ill Substance abusers eligible	Formula matching grant to states Subsidies for supportive services and housing services	All states; no estimate available on persons served	Ongoing
13. Shelter Plus Care	Persons who are homeless and mentally ill, substance abusers, and those who have AIDS	Tenant-based assistance like Section 8 certificate or voucher Sponsor-based assistance which reduces tenant units SRO moderate rehabilitation subsidy that reduces tenant rents Project-based rental assistance which reduces tenant rents	c. 2,300 as of 1992	Ongoing
14. Housing quality standards	Building, construction and housing codes apply to full housing stock HUD housing quality standards apply to assisted stock	State of repair of electric, heating, and plumbing systems, and interior and exterior of dwelling	NA	Ongoing

15. Site and neighborhood standards	Zoning regulations and local law enforcement apply to most neighborhoods HUD standards apply to supply-side subsidized stock	Regulates land use mix, noxious uses, safety Avoidance of areas with concentrated poverty; promote accessibility to services and resources	NA	Ongoing
16. Fair Housing Amendments Act of 1988; Americans with Disabilities Act of 1990	All residents including those with functional impairments and disabilities	Real estate transactions can not inquire about health status Landlords required to make reasonable modifications and accommodations to enable residency by disabled persons	NA	Ongoing

^aAll target groups must meet income-eligibility guidelines. The current criterion is an income $\leq 50\%$ of area median income.

^bNumber of elderly and handicapped participants follows Casey's (1992) estimate of 35% of households in assisted housing falling into these groups. Sources: Casey (1992); Interviews with the following: D. Hairre, Office of Elderly Housing, HUD, August 4, 1993; S. Krems, Office of Single Family Housing, HUD, August 6, 1993; S. Meisel, Office of Elderly Housing, HUD, August 6, 1993; J. Whaley, Office of Special Needs Assistance, HUD, August 4, 1993; J. Dawkins, Office of Demonstration Programs, U.S. Center for Mental Health Services, August 6, 1993. Abbreviation: NA, not applicable.