Housing as Health Capital: How Health Trajectories and Housing Paths Are Linked

Susan J. Smith*
University of Edinburgh

Donna Easterlow
University of Edinburgh

Moira Munro
Heriot Watt University

Katrina M. Turner
Glasgow University

This article explores the relationships between housing and health inequalities. It locates housing within a network of health resources that can either promote well-being or increase susceptibility to disease. Housing thereby contributes to the accumulation, or depletion, of the health capital of individuals and communities. Qualitative interviews in three British regions help specify the links between health capital, on the one hand, and the network of resources, environments, events, institutions, and social relations comprising the housing system, on the other. The findings show why, from a health capital/health-resources-network perspective, a segment of the housing system (owner-occupation) that generally appears therapeutic can have the opposite effect for people whose resilience is low or whose health is in decline.

There is now a substantial literature documenting the impact of housing environments on occupants’ health (Burridge & Ormandy, 1993; Ineichen, 1993;...
Lowry, 1991; Smith, 1989). There is also a growing interest in how people’s health affects their housing opportunities (Easterlow, Smith, & Mallinson, 2000; Robinson, 1998; Shanks & Smith, 1992; Smith, 1990). These two dominant approaches to housing and health (rooted respectively in unhealthy environments and institutional “selection”) are neither opposed nor mutually exclusive. Rather, they represent two snapshots (at any point in time) of what is, in practice, a dynamic interplay—unfolding over time—between housing careers and health trajectories. This article argues that conceptualizing housing as a source of “health capital” helps reconcile the “environment” and “selection” perspectives, and works towards a more comprehensive explanation for the character and persistence of health inequalities.

**Working With Health Capital**

In this section we show how the concept of health capital can be helpful in specifying how housing, as part of a wider health resources network, is implicated in the unequal patterning of health and well-being. Since various sorts of “capital” are currently in vogue in the literature on health inequalities, these serve as our point of departure.

Economists have long been concerned with the concept of an individual’s *human* capital, its accumulation (usually indexed by education, vocational qualifications, professional credits, and so on), and its importance in determining various positive life chances and opportunities (usually in relation to employment opportunities, access to wealth, etc.). In recent years, this concept has been appropriated by “third way” visionaries such as Giddens (1998, 2000) who advocate investment in human capital as an alternative to welfare transfers for tackling inequality. Human capital has, moreover, easily and routinely been built into standard economic models of health. Here, health measures are used as dependent variables, which are accounted for statistically by a range of individual characteristics whose presence or absence denotes particular levels of risk. These health “risks” include standard human capital indicators alongside measures of previous health, exposure to unhealthy environments, access/proximity to health care services, and so on.

Working in this vein, some economists have coined the term “health capital” to denote the balance of financial “investments” into, and “withdrawals” from, an individual’s store of potential health. This idea originates in the work of Grossman (1972), who depicts health as a durable good that is inherited, but depreciates over time. Investing in health capital is therefore “an activity where medical care is combined with other inputs in order to produce new health so as to partly counteract the ‘natural’ deterioration of health” (Muirinen, 1982, p. 5). When analyzing the processes by which health inequalities are generated, economists have, then, found it useful to regard health as a stock of capital, analogous to other forms of human or nonhuman capital. “Individuals’ states of health at any one time...
are assumed to depend on their initial stocks of health and on the extent to which they have invested in, or consumed that stock” (LeGrand, 1985, p. 18).

This human capital route to health capital is primarily concerned with what individuals can invest (financially) to maintain or enhance their personal health and well-being. The idea that a neighborhood’s or a community’s social capital may in turn be related to a locality’s collective health and emotional well-being is a more recent innovation. It is an attempt to acknowledge the extent to which health and well-being, illness and disease are consequences of (shared) contextual as well as (personalized) individual circumstances. To this end, social capital tends to be used as an umbrella term for concepts like social interaction and involvement (on the one hand) and trust and cohesion (on the other). That is, it gathers up all those social variables known to have a range of positive social effects, including health benefits (Mohan & Mohan, 2002). Inserting social capital into the health inequalities equation takes the emphasis away from individual causal or risk factors and turns attention rather to a range of social—and psychosocial—processes that mediate health experiences (Lochner, Kawachi, & Kennedy, 1999; Veenstra, 2000).

Social capital is now seen by some as a major causal influence on a population’s health profiles (Kawachi & Kennedy, 1997). This implies that tackling health inequalities is not just about economy and environment. The health of a nation hinges also on paying sufficient attention “to the integrity of the social structures in which we live,” tapping into issues around trust, community safety, participation in associations, and so on (Lomas, 1998, p. 1186). This has resulted in what we might term a social capital approach to health capital. Here health capital refers to the shared or collective accumulation of physical and psychosocial resources that, alongside “human capital,” help account for changes in health across the life course, or across a set of life courses (Benseval, Dilnopt, Judge, & Taylor, 2001).

There is broad agreement within the literature cited above that human and social capital are relevant to the explanation of health inequalities. In empirical research, however, these complex notions have featured mainly in quantitative analyses of standard survey data. Reduced to easily measured variables (usually labeled “risk factors”), they appear in the literature both as predictors of health outcomes and as indicators of something that is tentatively termed “health capital.” This preoccupation with quantifiable variables is criticized by Forbes and Wainwright (2001). It means that the concept of health capital itself is only weakly developed and its territory remains uncharted. Therefore, in the remainder of this section, we flesh out the notion of health capital, before going on to illustrate its relevance for understanding the complex processes that link housing experiences with health inequalities.

We regard health capital as a store of resilience that is built up or depleted as part of the trajectory individuals, households, and communities take through the changing networks of things, people, environments, events, and relationships
that shape their lives. To caricature this process we might say that as health capital accumulates, emotional well-being improves, health risks become less potent, resilience increases, health capital accumulates, etc. Likewise, as health capital declines, emotional stress increases, resistance to disease weakens, health capital declines, etc. Health capital is not therefore just (or even) a measure of current health status; it is rather part of the process of becoming sick or getting well. It bears the imprint of what has happened in the past, and contains clues about health and well-being in the future. Defined in this way, health capital is also a dynamic concept referring to experiences over the life course. It thus connects with a growing interest within public health and medical sociology in the molding of health through the life course (Davey-Smith, Hart, Blane, Gillis, & Hawthorne, 1997; Power, Matthews, & Manor, 1996; Vägerö & Illsley, 1995; Van de Mheen, Stronks, & Mackenbach, 1998). However, health capital is not unique to individuals, but may be shared by virtue of being part of a particular social group or inhabiting particular places at particular times. There are always systematic differences in how people’s histories, identities, and geographies are made, and the shaping of health capital is a part of this. Nevertheless, because of the complex networks influencing how susceptibility to illness and resistance to disease are built up and worn down over time, two people (or households, or communities) with a similar health profile, facing similar life events or environments, might experience different health outcomes in the future.

This conception of health capital has some resonance with Antonovsky’s (1979, 1987) idea of salutogenesis. Both approaches emphasize the importance of becoming or staying well, alongside a more usual concern with what makes people ill. Both recognize that health is dynamic and changeable; that people are never either sick or well, but always in a process of becoming, into various states of well-being and disease. Both position health in relation to life histories, linking it to both past and current resources; and both point to the importance of qualitative research, acknowledging that the meaning of an event, not just its objective characteristics, has an impact on health outcomes.

However, while Antonovsky is primarily concerned with individuals’ movements back and forth along a health ease/dis-ease continuum, we prefer to regard health capital as something pertaining to groups and communities, as well as individuals, and that is constituted within and by a complex health resources network. Thinking with networks has become quite fashionable in recent years, inspired in particular by Latour’s (1993) actant network “theory.” This is exciting for the purposes of the present article because it conceives of networks as being made up of nonhuman as well as human agents (or actants) which hold each other together—which influence each other—in a variety of ways. For health research, this approach has two advantages.

First, it encourages us to recognize that no individual social or environmental predictor of health works on its own, and to appreciate that how a particular health
resources network operates may vary through time and over space. Some people worry, for example, that it is difficult to demonstrate statistically the impact of specific housing environments on occupants’ health, or that it is hard to attach specific health gains to particular housing interventions (cf. Burridge & Ormandy 1993). This concern remains even where “risk factor” approaches are broadened into a “general susceptibility” model of the relationship between disease and environment (Ambrose, 1997; Hopton & Hunt, 1996; Hunt, 1993). But this is hardly surprising, because a housing event is likely to set off a whole range of other events, linking it into a complex network of health-relevant relationships. Effective policy is going to be based not on an appreciation of simple, or even complex, cause–effect links but on how that network functions as a whole. Therefore, we need an approach that allows particular nodes in the network to be scrutinized separately (housing, employment, lifestyle, and so on) yet that forces analysts to be mindful of the extent to which these are tied together. We need also an approach that can combine key elements of traditional material and environmental explanations for health variations with the increasingly popular psychosocial perspective (Elstad, 1998).

Second, while causal models (risk factor approaches to poor health) can be helpful in identifying what factors are salient to health status at a particular time in a particular place, they say little about the directionality of the link, even less about how these causal factors actually interact with people’s health, and virtually nothing about how relationships might be operating in both directions simultaneously. Certainly they do not engage with the sense that health is produced within a multidimensional web or network of relations among people and things. Thinking of social and personal well-being in terms of a health resources network helps address this complexity, acknowledging the importance of salutogenesis alongside pathogenesis, of self-efficacy alongside risk exposure, and of the psychosocial as well as material environments. The health capital/health-resources-network perspective also encourages the adoption of qualitative research alongside statistical models as a means of identifying where (which places, which points in individuals’ and households’ lives), and how, health capital is built up or depleted.

Housing as Health Capital

Our point of entry into the network of events, relationships, and environments that constitute people’s health, well-being, and resilience is the housing system. Housing features in health resources networks in a number of ways: by virtue of the health risks or protections associated with the character, condition, and location of different segments of the housing stock; through the sifting and sorting of social groups that are associated with access and allocation procedures in different parts of the housing system; and in terms of the psychosocial stress and emotional well-being that housing circumstances can engender.
Housing is often an afterthought in the literature on health inequalities (though, see Marsh, Gordon, Pantazis, & Heslop, 1999). Nevertheless, in Britain at least, one of the most intriguing health variations is that which maps the health divide onto housing tenure (by which we mean conditions of occupancy rather than length of stay). Mortality rates among owner-occupiers are 20–25% lower than among public renters (Filakti & Fox, 1995), and similar differences have been observed for morbidity rates (Gould & Jones, 1996). Moreover, these patterns persist even when controlling for social class.

There are three broad explanations for this. First, owner-occupation may have therapeutic, even curative properties. Second, people with health problems may find it more difficult to attain and sustain home ownership than the rest of the population. Third, alternatives to owning may be disproportionately attractive or available to people with health problems.

We have already considered the last explanation in a study of “medical” priority for rehousing in the social rented (public housing) sector. Social renting explicitly offers people whose health capital is depleted the chance to build it back up again, by offering preferential access to the better part of the (rented) stock. And our research suggests that this housing strategy is attractive to households and can work as a health intervention (Smith, Alexander, & Easterlow, 1997). However, in the last 20 years in Britain, this option has become less available and less appealing. Owner-occupation (homes owned outright or being purchased with a mortgage) has expanded rapidly, and at the expense of the public sector. Home owning is now the largest part of the private or market sector of the housing system, and of the housing system as a whole. This tenure shift has meant that a range of people who might previously have paid reasonable rents for homes obtained on the basis of need have begun to consider home ownership. Like other public sector tenants, people with health problems have, since 1990, been offered discounted sale prices under “right-to-buy” legislation. Like other potential buyers, people with health problems have had the opportunity to use home ownership as a tax-free investment, an appreciating capital asset, and a source of cheaper housing services in old age. As a consequence, people with health problems, who once relied on the public sector, are increasingly choosing, or being forced, to consider an alternative (Smith et al., 1997; Smith & Mallinson, 1996, 1997). Yet, people with health problems remain underrepresented as owner-occupiers.

To explore the remaining two explanations for this (see above), we conducted in-depth qualitative interviews among men and women with health problems, living in 84 households (the unit of analysis in this article) spread across three case study areas in Britain. The case study locations—in Scotland, Northern England, and Greater London—were chosen to capture a broad spectrum of housing, health, and general socioeconomic profiles. Study participants were approached, and invited to opt-in to the study, primarily via self-help groups catering to people with a range of physical and mental health problems. The aim in recruiting interviewees was
not that their stories should be typical or statistically representative, but rather that
the study should document as wide a range of housing and health circumstances as
possible. Therefore, although we supply numbers and proportions to support some
key generalizations, our primary interest is not in how widespread a particular
experience is (something that cannot anyway be inferred from the kind of sample
we have), but in the detail of how particular arrangements of institutions and social
relations work to enhance or undermine health and well-being.

All interviewees have health problems: Most often (among 70% of respon-
dents) these fall into the broad groupings of arthritis, cardiovascular disease,
chronic fatigue, and multiple sclerosis; less commonly they include cancer, di-
abetes, cystic fibrosis, and epilepsy. Almost 1 in 3 has a mental health problem,
usually depression (sometimes in combination with other conditions), and 1 in 5
has mobility difficulties. All those interviewed have some experience of being,
or trying to become, home owners. The study includes 67 current home owners
(33 had health problems when they bought their current property; 34 became ill
later on) and 17 who currently rent, either because they failed to gain access to
owner-occupation or were forced by their health to leave that sector. We inter-
viewed 33 men and 51 women, the majority of whom ($n = 65$) are in the age range
30 to 59 (that part of the life course in which households commonly attain home
ownership and consolidate their housing wealth. Nearly half (39/84) the house-
holders live with their partner (half of these adult couples live with dependent
children). Just over 1 in 3 (31/84) lives alone, and a further 8 are single parents.

Interviews normally took place in participants’ homes by prior arrangement,
using an open-ended interview guide that lasted between one and two hours. The
discussions were tape recorded with the interviewees’ consent and fully tran-
scribed. The transcribed data are stored both as anonymous household biographies
(to preserve the essence of whole stories) and as “Hyperresearch” codes to allow
common themes (identified through close repeated readings of the transcripts) to
be collated and explored. All the names cited in the text are pseudonyms, and
personal details have been disguised to preserve anonymity. There is no space
here for a detailed methodological discussion. However, in analyzing the data, we
have been mindful of the growing literature on rigor and validity in qualitative
research, on concerns surrounding the coding of materials, and on principles in-
volved in the selection and presentation of quotations (Mays & Pope, 1995; Smith,
2001).

**Health and the Housing Market**

Perhaps the most popular explanation for the health divide between owners and
renters is that owner-occupation is a disproportionately health-promoting housing
environment (Ellaway & Macintyre, 1998). This implies that access to owner-
occupation gives such a boost to households’ store of health capital that most
owners are well for much of the time. A number of interviewees allude to these “curative” properties of home ownership: 58 believe that owning gives access to homes that are good for health and quality of life; 14 of these and 9 others \((n = 23)\) associate their own move into home ownership with the attainment of a more therapeutic and enabling living space; 8 of these and 3 others \((n = 11)\) report specific health improvements during their time in owner-occupation. For example:

“My arthritis [has] been much better since I moved because I’m warmer and more happy, more relaxed. Stress levels are down” [Irene, arthritis].

“If I’d maybe been here 15 years before I probably wouldn’t have ended up having a heart attack” [Frank, heart disease].

“[As a renter] I felt very claustrophobic. So the positive part of this [home owning] is that I—I feel I can breathe” [Nicola, neuromuscular problems].

“[As a home owner] I was so impressed with what I could do for myself. I mean, it was like I always knew I could do it, it was just I was never allowed to … and doing all this stuff [made me think], Aah—I think I’ll go back to work now” [Lisa, arthritis].

“[The home we owned] was very—calming. I mean people would come into our home and they’d say—people would say—em, your house is very calming. There’s no hassles, there’s no stresses . . . . It was that kind of a home” [Colin, depression and mixed physical health problems].

Other interviewees report positive experiences of owner-occupation of a type that might be expected to enhance emotional well-being and store up health capital. Dorothy, for example, after illness, found her home to be disabling. She would have preferred to move into a rental accommodation, but felt she was forced to buy in order to secure a suitable home. However, once she came to terms with this, she found the move therapeutic, at least for a while:

I: Has your health changed at all since you moved here?

D: Yes, I think it has. Not so much physically, but emotionally I feel better. Because I’m much more independent now than I was . . . I’m now looking forward and planning things whereas in my old house, because I was so limited there, I didn’t feel that I could do anything other than just sort of sit around . . . . So yes, emotionally, I’ve improved.

Moving to a home she felt comfortable in and had control over was associated by Dorothy with a whole suite of emotional and behavioral responses that seem health promoting, that helped her to cope with her physical condition, and that might enhance her resilience against future health risks.

These findings are not surprising since, on the whole, owner-occupation, despite being an uneven and unequal tenure sector, contains the best quality homes in the best overall conditions. Additionally the terms on which owners and buyers occupy their homes—the social relations of ownership—may also have beneficial health effects. Indeed the Black Report recommended that “. . . there must be a much greater extension of the rights and privileges associated with owner-occupation to the tenants both of local authorities and private landlords. Health considerations are certainly among the factors which justify such extension”
Housing as Health Capital 509

(Townsend & Davidson, 1990, p. 189). It is not without reason that owner-occupation (notwithstanding its diversity) is widely regarded as a healthy housing environment (Ineichen, 1993; Macintyre, Ellaway, Der, Ford, & Hunt, 1998).

However, in the remainder of the article we consider the possibility that the health-promoting elements of home ownership are only part of the story. Owner-occupation does contain institutions, environments, and experiences that can build up health capital, but it is important also to explore the remaining explanation for the health profile of owner-occupation, namely that it is partly a product of health selection. To this end, we ask, Do some people with health problems find it hard to attain home ownership? and, Do owners whose health problems get worse find it difficult to sustain their housing position? If the answer to either question is “yes,” then the fact that owners are, on the whole, healthier than renters may be as much about social exclusion as it is about health promotion.

This is not to suggest that either one housing process (health promoting) or another (health damaging and selective) is in play for any individual or group at any one time. The relationships between housing and health are complex, and we can expect owner-occupation to interact in multiple ways with the accumulation, maintenance, and depletion of health capital. Nevertheless, it is only by exploring these interactions that it is possible to establish the extent to which, for people who are sick or vulnerable, for people whose health capital is low, home ownership constitutes a problem rather than a solution.

Little is currently known about the way housing market mechanisms become entangled with home buyers’ health histories (through, see Easterlow et al., 2000). However, there are two points in the path through home ownership that merit particular attention, given our concern with why people with health problems are underrepresented as home owners.

First, we consider what happens when people with health problems try to access owner-occupation. Our argument here is that although owner-occupation represents a potentially therapeutic outcome for a group (people with health problems) who need this most, the process of accessing this sector can be stressful in ways that can damage health prospects. Furthermore, some of the stressors involved are disproportionately likely to be encountered by people with a history of health problems. For this group, therefore, difficulties in accessing home ownership may not only be discouraging, but may also undermine emotional well-being and erode health capital.

Second, we explore what happens when healthy owner-occupiers get sick; or when preexisting health problems among owner-occupiers get worse, or fail to improve. Again, owner-occupation contains the potential to operate as a therapeutic landscape. In practice, however, we show that people’s experiences are mixed. Once-enabling housing environments, and once-appealing conditions of housing occupancy, can prove increasingly unhealthy for those whose condition is worsening, whose resilience is already low, and who may not be able to adapt
their homes to meet their health needs. The end point may be a process of selective exit from the sector.

**Accessing Owner-Occupation**

If accessing owner-occupation is a way of enhancing health capital, it is important for people with health problems to find a way to tap into this. Two key sets of factors seem to affect people’s opportunities in this respect. The first relates to ability to pay; the second is concerned with the process of finding a physically suitable and emotionally appealing property.

**Ability to pay.** People with health problems often have decreased incomes and increased expenditures, and this obviously has bearing on their ability to pay for housing and to compete in the marketplace. The resulting financial insecurity puts some people off buying altogether, especially (but not exclusively) in the higher priced case study locations that are shown in Table 1.

Moreover, when people with health problems do decide to buy, their concerns about housing finance seem well founded. Notably, whereas for most home buyers, “ability to pay” (the key criterion for entry to owner-occupation) effectively means “ability to secure a mortgage,” interviewees in this study point out that “ability to secure a mortgage” is not, in practice, the same thing as ability to pay. And the mismatch between these (i.e., the fact that some people could pay, but cannot get a mortgage) can work against the interests, and indeed the health, of householders.

The range of barriers encountered by interviewees in translating their incomes into mortgages is illustrated in Table 2. This offers a glimpse of the wide range of resource networks an encounter with the access rules for owner-occupation.

<table>
<thead>
<tr>
<th>London</th>
</tr>
</thead>
<tbody>
<tr>
<td>“... Because of my health, em, I would be so afraid owning a place, you know, I’d be worrying I’m going to lose it tomorrow, I’m going to be homeless tomorrow, even though that wouldn’t be logical. Logic doesn’t come into it if you’re in anxiety state... I think it’s sort of something for younger, healthy people” (Kathleen: depression).</td>
</tr>
<tr>
<td>“If you felt that your life expectancy was markedly less, you might not wish to take on the expense of buying... moving itself is traumatic, so it’s not something that you do lightly” (Ian: back/spinal problems).</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Scotland</th>
</tr>
</thead>
<tbody>
<tr>
<td>“You’ve got the repayments, you’ve got rates, anything goes wrong with the building, you’ve got the repair, maintenance. I think it’d be too much worry... No I don’t think I would buy a property. I’d be too scared of getting into debt. And not being able to find the repayments and the threat of them going to take the house off of you, you know, because you can’t make the repayments or because you need to find the money for something else” (Elaine: mixed physical health problems).</td>
</tr>
<tr>
<td>“It’s also the responsibility. [If you rent rather than own] you don’t have to go through the process of working out how much it’s going to cost, phoning for an estimate, getting somebody round to do the work and then paying them” (Lesley: back/spinal problems).</td>
</tr>
</tbody>
</table>

---

**Table 1. Some Reasons for Avoiding Home Ownership**

<table>
<thead>
<tr>
<th>London</th>
</tr>
</thead>
<tbody>
<tr>
<td>“... Because of my health, em, I would be so afraid owning a place, you know, I’d be worrying I’m going to lose it tomorrow, I’m going to be homeless tomorrow, even though that wouldn’t be logical. Logic doesn’t come into it if you’re in anxiety state... I think it’s sort of something for younger, healthy people” (Kathleen: depression).</td>
</tr>
<tr>
<td>“If you felt that your life expectancy was markedly less, you might not wish to take on the expense of buying... moving itself is traumatic, so it’s not something that you do lightly” (Ian: back/spinal problems).</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Scotland</th>
</tr>
</thead>
<tbody>
<tr>
<td>“You’ve got the repayments, you’ve got rates, anything goes wrong with the building, you’ve got the repair, maintenance. I think it’d be too much worry... No I don’t think I would buy a property. I’d be too scared of getting into debt. And not being able to find the repayments and the threat of them going to take the house off of you, you know, because you can’t make the repayments or because you need to find the money for something else” (Elaine: mixed physical health problems).</td>
</tr>
<tr>
<td>“It’s also the responsibility. [If you rent rather than own] you don’t have to go through the process of working out how much it’s going to cost, phoning for an estimate, getting somebody round to do the work and then paying them” (Lesley: back/spinal problems).</td>
</tr>
</tbody>
</table>
Table 2. The Problem of Securing Mortgage Finance

<table>
<thead>
<tr>
<th>Nature of Employment</th>
</tr>
</thead>
<tbody>
<tr>
<td>&quot;If you’re ill, you’ve got less job security . . . . I wanted to take out a mortgage for the other half of the flat . . . [but] they won’t give me a mortgage for the rest of it because I’m not in permanent work, even though I’m earning, you know, a good salary at the moment&quot; (Molly: arthritis and depression).</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Income From Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>“People that are on sickness benefit through no fault of their own, they can’t get a mortgage” (Ellie: arthritis).</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Insurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>“Being refused life insurance, we didn’t get as far as being refused a mortgage, but, you know . . . life insurance was a condition of the mortgage” (Peter: depression).</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>All in All</th>
</tr>
</thead>
<tbody>
<tr>
<td>“Lending companies don’t view people with long-term health problems very favorably” (Lesley: back/spinal problems).</td>
</tr>
</tbody>
</table>

taps into—the worlds of work, welfare, personal financial services, and so on. The table shows that, in addition to low incomes overall, people with health problems feel disadvantaged by lenders’ aversion to flexible working, interrupted incomes, and/or frequent changes of employer; the problem of securing a mortgage when some proportion of income comes from state benefits; and the difficulty of finding appropriate life insurance (and related financial services) to act as a safety net. Furthermore, people with health problems often have to negotiate several barriers at once, and each one adds to both the financial and psychosocial costs of attaining home ownership.

Perhaps the most draining of the experiences reported by interviewees is the tendency among mortgage lenders not to include income from benefits when calculating lending limits. Take the case of Ellie and Tom. They rent their home from the Council (the public sector landlord; i.e., they live in public housing) and wanted to pursue their right-to-buy (so that they could own their existing home). Family health problems led them to put their application on hold—something they now regret, because “it would be cheaper for us to buy this property than rent it.” They go on to say: “We went to the mortgage people . . . but because we’re both on benefits and Tom’s only got his . . . pension, they won’t touch us.”

Anthony also feels excluded from home ownership because his income now includes benefits. He has cystic fibrosis and felt that he would only get a mortgage if he failed to disclose his condition. However:

I thought that would just be folly and they would be able to see through my disguise, because obviously I would have to declare what income I was getting and they would see I was getting DSS [Department of Social Security, i.e., welfare] benefits and they would wonder why. So I decided that right, I can’t get a mortgage, I can’t buy.

The legacy of a benefit-dependent period can make the search for mortgage finance stressful and dispiriting, especially when more than one lender rejects an
application. In the end it may be necessary to accept a whole suite of restrictive conditions, in addition to higher costs (particularly on insurance), than would normally be anticipated in the mainstream mortgage market. In one case, for example, where a borrower was moving from benefits into work, the lender required a salary to be paid directly to them, someone to act as guarantor, and evidence of subscription to a mortgage payment protection insurance. On the one hand, this is about responsible lending, but on the other hand, such hurdles can seem patronizing and overly controlling, setting up stressors that undermine emotional well-being and wear down resilience.

In short, the process of securing housing finance is not just about ability to pay, and translating incomes into mortgage finance can be more problematic and, hence, potentially more stressful for people with health problems. Few interviewees had been categorically refused mortgage finance—just 10 had never owned, despite wanting to, although a further 36 settled for a lower mortgage than they needed. Nevertheless, the added cost in time, stress, and money that people with health problems can incur when engaging in these negotiations all add to those psychosocial stresses that undermine rather than enhance health capital.

The fact that people with health problems can find access to mortgage finance more costly than people who don’t have health problems implies too that they can buy less house for the same income. This can mean compromises on housing quality, location, state of repair, maintenance costs, home insurance premiums, and so on. So not only is health capital undermined by the stress of getting into the owner-occupied sector, but health potential may be limited by the kinds of homes available to people with health needs (an issue taken up later).

Finding a suitable property. Markets are about both ability to pay and ability to compete on equal terms for the products on offer. In this section we consider the second of these, showing that although people with health problems may secure less house for the same money (compared to their healthy counterparts), their route into a property of their choice may also be longer and more stressful. Any therapeutic effect of achieving home ownership might, in short, be compromised by the extent to which resilience is undermined en route.

For some prospective buyers, shopping for a new home can be fun (Bondi, Christie, Munro, Smith, & McEwan, 2000). For people with health problems, however, the process can be rather different. Only 4 interviewees did not feel their health problems affected their house search, while 18 drew attention to particular difficulties posed to people with health problems by the way the property market works. Dorothy tells how daunting it can be when a turning point in health and well-being precipitates a change in the housing career:

I had very mixed feelings because basically we did not want to move. We were very happy in the flat we had. We liked the area and everything round it. So both of us felt that we were being forced into making a decision about moving [that] we wouldn’t have necessarily taken . . . . So I was looking with very mixed feelings. I knew—I knew I needed to move
because I was a kind of prisoner in that flat but then I didn’t want to move because, you know, everybody was there that we—all our friends and everything.

Dorothy and others like her face two key sets of difficulties in finding a home to buy. These are illustrated in Tables 3 and 4. First, Table 3 suggests that although the owner-occupied sector contains the “healthiest” living environments generally (in terms of the condition of the housing stock), it does not routinely supply, at affordable prices, homes packaged with the aids, adaptations, facilities, and social care that many households with health problems and mobility difficulties require (Morris, 1991; Rolfe, Leather, & Mackintosh, 1993). Remedying this was one aim of the British Government’s 1999 extensions to building regulations for new homes; however, it has been argued that these regulations still do not go far enough (Madigan & Milner, 1999). Certainly the stock of housing effectively available to people with health problems and impairments is less extensive than the stock of housing available to the rest of the population in all three case study areas.

The second difficulty identified by respondents concerns the extent to which people with health problems have an equal opportunity to compete in the marketplace. The problem here is less about housing costs and supply than about the flow of relevant information about what is on the market. Markets depend for their efficient operation on a free flow of information. In the housing market this is secured through a network of intermediaries, mainly estate agents (but also, especially in Scotland, solicitors, surveyors, and financial advisers). Estate agents are there to let potential buyers know what is on offer. Their function is to disseminate the information that the market needs to work. To this end, estate agents help organize, and so simplify people’s search process. They make competing in the marketplace possible and manageable. They do this partly by grouping properties

Table 3. Limited (and Disabling) Choices for People With Health Needs

<table>
<thead>
<tr>
<th>Scotland</th>
<th>&quot;We looked for properties with flat access and it was almost impossible . . . The limit of the property available which is accessible . . . makes the choice for you&quot; (Nicola: neuromuscular problems).</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>&quot;I was looking for a barrier-free house, if you can find such a thing. And I’d looked and looked and looked . . . I was getting a little desperate . . . Builders are not required to build suitable properties, so they don’t&quot; (Kathy: postviral fatigue).</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Northern England</th>
<th>&quot;Now I think I would have to look for a bungalow. But I don’t know that there are any bungalows round here that I’d like to live in&quot; (Jessie: multiple sclerosis).</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>&quot;They were like rabbit hutches. I mean, I couldn’t have turned round in a wheelchair . . . We’d have moved out the area if we got a decent bungalow, but there was none&quot; (Gail: arthritis).</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>London</th>
<th>&quot;There were just no suitable properties really on the market that fitted my criteria&quot; (Elizabeth, depression).</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>&quot;I have fought long and hard against being labeled . . . I still wanted to live in a home that didn’t have . . . all the sort of reminders that you are a wheelchair person . . . I began to feel pessimistic about it, because I didn’t think we were ever going to find it&quot; (Dorothy: back/spinal problems).</td>
</tr>
</tbody>
</table>
Table 4. Information in the Housing Market

Scotland
“The estate agents would say, ‘Oh we’ve got something for you, you know, da di da di da.’ And my husband would feel, ‘Oh good’ and everything, and then I’d say ‘... but there are eight steps up to the front door [and] it’s not going to be easy to adapt it to a ramp’... so the business of house hunting was made into a burden” (Nicola: neuromuscular problems).

“I looked at hundreds of houses ... I went to look at a property and it had about six steps to get up to the front door, or it claimed it was a bungalow and you got there and it had an attic conversion, you know” (Lisa: arthritis and depression).

Northern England
“You read through all these estate agents’ leaflets and nothing mentioned disabled access ... there were nothing on paper ... They say what the house is like, and when you go it’s completely different. It’s right depressing” (Gail: arthritis).

London
“One of the big problems when you’re doing this is [that] estate agents have no idea when you ask them, ‘Is the building wheelchair accessible?’ They’ve visited the building; it’s not one of the things they’ve ticked off on their questionnaires ... They haven’t got a clue” (Ian: back/spinal problems).

“I just kept going round them but they said, no there’s nothing on the books ... It was a really hard time ... Not one single person came back to me with anything ... Of all the estate agents I was with, nobody ever called me with anything [to view]” (Sophie: arthritis and depression).

A number of narratives suggest how the resulting information deficit may impinge on health capital. Dorothy, for example, needed to avoid the physical exertion of viewing potential homes. She left this to relatives, but this also proved stressful because “I didn’t feel that I was in as much control of it all as I wanted to be and I had to be relying on lots of other people.” She felt that so much effort...
had to be put into checking access, layout, and adaptability, that aesthetic issues, particularly outlook and atmosphere, were overlooked. Again the result is a process that is as likely to undermine resilience as it is to enhance social well-being.

Jack feels similarly dependent and increasingly depressed because he feels trapped in his flat, which is on two levels and not on the ground floor. He bought his home by exercising his right-to-buy from the Council. Although he now needs to move, the local authority will not allow him back onto their waiting list and they will not sell him a different property in exchange for the current one. Jack’s priority is to move into a more enabling living space, but he does not know where to start: “I know I’ve go to move but I can’t do anything about it . . . I can’t get out and look at the estate agent’s books . . . . I haven’t got a clue.” Our interpretation of Jack’s narrative is that the information vacuum surrounding home selling and buying is contributing to his loss of independence, quality of life, and emotional well-being.

All this suggests that, irrespective of income, the housing market can fail to work as well for people with health problems as for people without them. The process of finding (or not being able to find) a house suited to health needs—one that should be well placed to help maintain health capital—can be stressful in ways that undermine health and well-being. And, as we shall see in the next section, if people’s resilience is low when they enter the sector, their well-being within the sector may subsequently be compromised.

*Sustaining Home Ownership*

People with health and mobility problems are often as keen on home ownership as anyone else. Sixty-two of the 84 householders interviewed had something positive to say about owning a home of their own. They recognize its importance as a source of wealth; they value the freedom to extend, improve, and adapt their homes; and they enjoy the sense of safety and security that comes with having a place of their own. But while owner-occupation may have some therapeutic qualities, it is no guarantee against the onset or progression of disease and disability. In this section we note two sets of circumstances in which worsening health can both undermine the well-being of owners and put their homes at risk.

First, declining health is often associated with decreasing incomes and increased expenditure. As Nettleton and Burrows (1998) have already shown, this change in households’ balance sheets can affect the sustainability of home ownership and is sufficiently stressful to undermine health still further. Second, even if housing outlays can be sustained, poor health and increasing disability can produce a growing mismatch between the character and condition of homes on the one hand and occupants’ health and mobility needs on the other. This is a route towards unhealthy and disabling living environments, and to the kind of psycho-social stressors that further erode health capital.
Meeting housing outlays. Sixty-one of the 84 households in this study have one or more earners whose health has, at some point, edged them out of the labor market. Obviously anyone whose income drops can be in trouble in a system where ability to pay is all-important. But for people with health problems, it is not just that incomes go down; expenditures nearly always go up (heating bills, prescription charges, help with cleaning, gardening, essential repairs, and so on). This can be disastrous for mortgage payments, putting both homes and health at risk. Table 5 consists of four vignettes that illustrate this cycle of events. These examples suggest that housing costs can nudge people into a web of experiences and relationships that can undermine health capital, wear down resilience, and impair emotional well-being.

Overall, 1 in 4 of the 67 households currently in owner-occupation are finding it hard to meet their housing outlays. Time and again, interviewees link this difficulty with their steadily failing health. Margaret sums it up:

I just think a mortgage is a struggle… It’s quite soul destroying to see your money go out as quickly as it comes in… I realized all that stress had probably caused or helped towards the heart attack… It was just a nightmare.

The stress of eventually being forced to quit owner-occupation for financial reasons can be enormous, as Margaret went on to say:

I’d got a letter from them saying that [the house was about to be repossessed] and I was paranoid. I thought, who do you—where do you go? I mean, never having been in debt before, I thought, oh no… I was terrified. I don’t know how I managed to carry on at work or anything because that was all I could think [about]…

And the move itself can be a further financial drain. Ellie, for example, told us how, because she needed to sell her home quickly to avoid getting further into debt, she let it go at “a knock-down price.” While this kind of experience has already been flagged by Nettleton and Burrows (1998) as a health hazard, the people we spoke to further indicate a range of indirect health hazards that may stem from an enforced change of tenure, such as loss of control, loss of self-esteem, loss of status, experience of a disruptive life event, and so on (Table 6).

The pathway out of home ownership can, then, be as stressful as the pathway in, as the onset or progression of health problems interacts with institutional rules and priorities to adversely affect people’s quality of life and undermine their ability to retain their home.

Maintaining a healthy home. Having outlined some ways in which entry to, and exit from, home ownership can be health selective (partly accounting for the health divide between home owners and the rest), it remains to consider just how therapeutic the home environment can be for those owners with health problems who are able to meet their essential housing outlays. As might be expected from
Table 5. How Poor Health and Housing Problems Compound One Another

<table>
<thead>
<tr>
<th>Alison</th>
<th>Dawn</th>
<th>Gillian</th>
<th>Lesley</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enjoyed owning but became depressed.</td>
<td>Has multiple sclerosis.</td>
<td>Has mixed physical health problems and depression.</td>
<td>Is in constant pain due to back/spinal problems.</td>
</tr>
<tr>
<td>Left a stressful job; became too depressed to work . . . or manage money: “It’s very difficult to keep track of your finances.”</td>
<td>Can no longer work, and is separated from her husband.</td>
<td>Had to stop work; now has sense of foreboding: “What if my husband had to give up work, what would happen to the mortgage?”</td>
<td>Her own income halved; her husband cared for her, but went on to lose his own job “through my illness.”</td>
</tr>
<tr>
<td>Fears losing her home: “. . . one of the biggest worries that you can have is that you don’t feel secure in your house . . . . The security of home ownership means a lot to me.”</td>
<td>Fears losing her home: “I was just going to bed at night and thinking, oh God, how am I going to pay it [the mortgage and the bills]? . . . I didn’t know how I were going to do it. I were worrying.”</td>
<td>I: “[So] it was going to be a problem to meet all the bills, how did it make you feel?” G: “Quite depressed. Yeah, just fed up. You know, I had my health problems, now I’ve got added problems . . . .”</td>
<td>Fears losing her home: “A lot of time is spent worrying . . . . These financial problems . . . stemmed directly from my being ill . . . keeping up with [mortgage] payments is . . . a fairly constant concern.”</td>
</tr>
<tr>
<td>Had insurance safety nets but these did not cover depression; has (state) income support for mortgage interest but this does not cover costs.</td>
<td>Despite (eventually) securing income support for mortgage interest: “I just don’t buy myself anything . . . I haven’t got the money to spend.”</td>
<td>Has a steadily mounting overdraft that is used to bridge the gap between income and expenditure.</td>
<td>Can just meet mortgage payments, but has nothing left over for maintenance and repair.</td>
</tr>
<tr>
<td>I: “Has that had any effect on your health?” A: “Yeah definitely. It has. . . . I sort of lost whole days just obsessing about [money problems].”</td>
<td>“. . . I made myself ill just worrying because . . . that’s what happens with MS . . . I were causing relapses because I was worrying.”</td>
<td>“I do feel that stress does start affecting the arthritis. I find if I’m stressed about anything . . . that is the time when I’m worse.”</td>
<td>“I think all of this has led to . . . [specific health problems] . . . . I think it’s—it has inhibited my returning to full health . . . .”</td>
</tr>
<tr>
<td>Is making plans to sell and then rent.</td>
<td>Wants to rent, but is unable to sell.</td>
<td>House is not at risk, but basics have to be sacrificed.</td>
<td>Home is at risk and this is a constant concern.</td>
</tr>
</tbody>
</table>

the literature, there are some health gains to be made. However, what is also clear is that a change for the worse in health can very quickly affect people’s use of, and quality of life within, their home. And when this happens, home ownership can become a rather inflexible, and sometimes health-damaging, option.

Brenda, for example, has chronic fatigue and her condition has deteriorated to the extent that she can no longer get up and down the stairs to her flat. This had an immediate effect on both her emotional well-being and her health behavior:
Table 6. Leaving Home Ownership: Emotional Well-Being and Psychosocial Stress

<table>
<thead>
<tr>
<th>Loss of Self-Confidence and Esteem</th>
<th>“That was a frightening process, em, a very emotional process and I was almost in tears every night” (Christopher: depression).</th>
</tr>
</thead>
<tbody>
<tr>
<td>A Drop in Social Status</td>
<td>“You lose your home and you move from Hollywood and you end up in the Bronx” (Ellie: arthritis).</td>
</tr>
<tr>
<td></td>
<td>“It’s just the decision that hasn’t been made yet. I can’t quite bring myself to make it . . . but I would feel like it was a step down” (Alison: depression).</td>
</tr>
<tr>
<td>A Sense of Isolation</td>
<td>“It was isolating . . . I didn’t like it—I still don’t really” (Freda: arthritis).</td>
</tr>
<tr>
<td></td>
<td>“Whenever I go out, I meet people I know . . . It’s gonna be a wrench if I have to move away from here to somewhere different . . . I’d be lonely” (Jack: cardiovascular disease).</td>
</tr>
<tr>
<td>A Threat to Family Life</td>
<td>“There was a level of stress about it, you know, because we were going to have to sell, you know, the family home, which none of us wanted to do . . . that was then, from my point of view, a threat literally—this is literally—a threat to our marriage” (Nicola: neuromuscular problems).</td>
</tr>
<tr>
<td>A Loss of Personal Coherence</td>
<td>“[I was] both emotionally and physically miserable . . . It was [a] very important thing to me, you know, and it was the bit of normality I was clinging to . . . . It was just the final blow really. It was a worry . . . It was bad—it was bad for my health” (Ellie: arthritis).</td>
</tr>
</tbody>
</table>

“I took a ground floor flat for two months this summer because I just felt as if I was going to have a nervous breakdown. That’s why I started to smoke.” There are other people in the study whose housing and health circumstances mean that, in the end, they really need to move if they are to secure a more enabling environment. For the most part, however, when homes become disabling, people want to stay, even though this may mean stretching their finances to the limit.

Home owners can be used to stretching themselves of course, because they believe property prices will rise and renovations/extensions will add value. But for people with health problems whose home environments have become disabling, things are often rather different. Adaptations, for example, may not add value. Andrew has multiple sclerosis, and he combined savings with a remortgage to adapt his home to his changing needs. We asked how much these adaptations, which cost more than the original purchase price of the property, would add to the value of his home: “Obviously a little bit, but not anywhere near [that] amount of money. But we’re not doing it from that point of view. It’s not being done to add value; it’s being done to make life easier for me.” People in this position can be caught in the ethos of self-reliance that is all part and parcel of the ideological underpinning of home ownership (Gurney, 1999). They feel they should be able to fend for themselves. This feeling is often reinforced by their encounters with the state. Freda, for example, lives in a house that is damp to the extent that it is affecting the whole family’s health. They paid thousands of pounds to put in fans and ventilation, and to redecorate, all to limited avail. In the end, they turned to the local Council, and spent 3 years trying—without success—to secure grant
assistance. Deborah’s experience is equally telling. She has multiple sclerosis and the adaptations she required were extensive. The occupational therapist advised her to sell up and rent. This advice may have been well-intentioned, but it left Deborah feeling guilty when she decided to move forward with her grant application. You were, she said, “basically getting told what you’re doing people out of.”

People we spoke to recognize that the stress, first, of finding they cannot do it themselves, and then, second, of discovering how difficult it is to secure help can all be damaging to health. Nicola’s story is instructive. She has neuromuscular problems and so checked with an occupational therapist, prior to buying her new home, that adaptations on the property would be feasible. She received the go-ahead, and during the next 2 years several architects were asked to draw up plans; occupational therapists came and went and took long periods of sick leave; social services said first that things were moving forward, then that the work would be too disruptive; the grants department said the procedure was going ahead, then that it would cost too much. Every small decision took months to make and key professionals made themselves unavailable for long periods. “I was really having to fight my own battles and I had just simply run out of energy after 2 years . . . it was detrimental to my health,” she said. In the end she moved on.

Some people can neither handle a move nor afford to repair, maintain, or adapt their living environment. In these circumstances home owners with health problems face the ultimate irony of having achieved a position in the healthiest tenure sector, yet finding that this space is increasingly hazardous to health and difficult to manage. Such spaces are hazardous because of their physical condition, but also because they are so stressful to occupy. So, alongside a picture of how owner-occupation boosts the accumulation of health capital, we have evidence of how it gradually wears people down.

Elizabeth, for example, had never wanted to buy, but felt she could not afford to rent. She thinks that the process of buying was implicated in the onset of her health problems. She describes a network of relationships and events that we interpret as having slowly undermined her health. With her health capital at a low ebb, a stressful housing transaction was implicated in the onset of depression.

I: Now we established that when you bought this property you were in good health. Can you tell me a bit about how and when this changed?

E: I had a lot of hassle, em, buying this property . . . When I moved into the property I found, em, various problems . . . I got badly ripped off, by [the person] who did the rewiring for me, financially . . . My mother was ill at the time and I was in a very stressful job too . . . The process of moving and say 6 months afterwards, it was a very, very, very stressful time. Ha ha. And I think that was a large contributing factor to [my depression] because everything . . . I touched absolutely just fell apart or went wrong.

For a while Elizabeth felt at least some benefits from her new home, in which she felt safe and secure. But now the worry of maintenance and repairs, the responsibilities of home ownership, have become too much and she feels it makes her depression harder to deal with and to recover from. The upshot is that
I see the flat as a liability. I don’t see it as a joy. Em, I don’t think of it as being an investment; I just see it as a problem . . . It’s another thing to worry about basically, that’s all it is . . . It’s another demand that I can’t get away from . . .

This trajectory of health mediating housing outcomes, of housing attainment mediating health, of health affecting housing options is a familiar theme in this study. Ann, for example, has arthritis. She and her husband bought at the cheap end of the market, and when he, too, had to leave work due to poor health, they could no longer afford to maintain a healthy home. Windows need replacing, central heating needs installing, and the whole experience has left them feeling vulnerable and depressed.

What we are seeing here is not simply about costs. The problems arise also from the way that people’s housing circumstances and health histories interact with the professionals, institutions, policies, and practices that are designed to keep people at home—in their community—with dignity, should their health begin to fail. It is surprising how many interviewees feel resigned to moving on, not because they cannot manage their housing costs, but because they cannot see a way to make their housing accommodate their health needs (see Table 7).

Some of the people we spoke to would like to remain in their homes, but face the prospect of a move simply because the institutional arrangements to enable them to stay are not working as they should. Others, however, find that home

<table>
<thead>
<tr>
<th>Table 7. From Staying Put to Moving On</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Scotland</strong></td>
</tr>
<tr>
<td>“I’m happy in my flat; I’m more than happy. But it’s just the stairs . . . [and] I’m not going to be better off [as a renter]; I’ll be worse off.” (George: cardiovascular and other physical health problems).</td>
</tr>
<tr>
<td>“I’m happy where I am at the moment . . . I like the house, I like the area, I feel comfortable here but I am prepared that I may have to move in the future” (Elspeth: arthritis).</td>
</tr>
<tr>
<td>“Well, I just don’t know how the future’s gonna go . . . There will probably come a time that we will have to move again . . . to a house that’s on the one level” (Gillian: mixed physical health problems and depression).</td>
</tr>
<tr>
<td><strong>Northern England</strong></td>
</tr>
<tr>
<td>“I couldn’t manage in the house . . . I just couldn’t manage at all . . . It was impossible for me to live in that house on my own then . . . It was just impossible” (Ellie: arthritis).</td>
</tr>
<tr>
<td>“I’d go for a place where I could manage easier . . . I didn’t used to feel like moving away but because of having a problem with my health, I’m thinking” (Freda: arthritis).</td>
</tr>
<tr>
<td>“I’m seriously thinking at some stage I’m gonna have to go into a bungalow. This is one of the things I’ve got to worry about . . . It’s a big wrench, having to give your home up” (Eddie: asthma).</td>
</tr>
<tr>
<td><strong>London</strong></td>
</tr>
<tr>
<td>“I can see the day coming when I’m going to need to be on one level, either in a flat or in a bungalow . . .” (Hilary: phobias and physical health problems).</td>
</tr>
<tr>
<td>“The pressure of home ownership . . . was making the depression worse. I talked to my psychiatrist about it, em, and, decided it was worth trying the council . . .” (Elizabeth: depression).</td>
</tr>
<tr>
<td>“I would really love to get out of here. To go over to where my brother lives . . . to get a little bit more fresh air . . . And, em, to get away from the stairs” (Glenda: mixed physical health problems).</td>
</tr>
</tbody>
</table>
Ownership has become a heavy burden and something that they simply cannot cope with on top of their health problems. Either way, what should have been an opportunity has turned into a stress; and what should have been a therapeutic housing outcome has become a factor undermining health capital, damaging social well-being, and, in the end, leaving mainstream home ownership to those who are lucky enough to stay well.

**Policy Implications**

Owner-occupation is an attractive housing option in Britain. The “rules” of occupancy are flexible, giving people a sense of autonomy and control; the investment is tax efficient and shows good long-term growth rates. There is also more choice for owners than for renters—the stock of housing is larger, and tends, on the whole, to be in better condition. It is hardly surprising that so many households, irrespective of their income, health, or wealth, aspire to own their own home. Yet the evidence presented here is that home ownership is not as “healthy” an option for sick people as it might be for those who are well. Some practicalities of this are considered elsewhere (Smith, Easterlow, & Munro, in press), but broadly the problem is that markets are not designed to “care.” They are mechanisms for distributing goods according to ability to pay in a system where information flows freely and evenly among participants. However, people with health problems often have needs that the market does not respond to, may require information that is rarely available, and sometimes have incomes that are difficult to turn into mortgages.

There is no tradition of explicit attention to health needs in the institutions of the housing market, but given that the market is now required to accommodate a range of needs previously absorbed by the public sector, there is an argument for challenging this. This means not only building some of the more attractive aspects of market provisioning into the allocation of social rented homes, but also building some of the caring qualities of the social sector into the workings of the housing market. We suggest that there are three practical starting points in the experiences of people with health problems who have been trying to make home ownership work. First, they ask for the same options as everyone else in using their incomes—even where these derive wholly or in part from benefits—to secure mortgages. Second, they look for a market that routinely supplies affordable properties with what are currently regarded as nonstandard specifications. Finally, they aspire to have a sense of security in, and control over, their living space, even where (financial or practical) help is required with maintenance, repairs, improvements, and adaptations.

**Conclusion**

This article explores some previously unacknowledged routes by which housing circumstances map onto health inequalities. By locating housing within (and
as part of a wider health resources network, we have shown how even a potentially therapeutic environment might undermine health capital and increase susceptibility to disease. Working in three case study areas within Britain, we have argued that although owner-occupation contains some demonstrable health (and other) benefits, the emotional stress and practical difficulty of gaining access to, and maintaining a suitable home within, that sector can be emotionally draining, disabling, and damaging to health.

Our findings suggest that the network of environments, social and professional relations, institutional rules and procedures, and conditions of occupancy of housing play a significant role in the constitution of health capital, and in the mediation of health inequalities. The study helps explain why currently, and ironically, the most therapeutic sector of the British housing system may be least useful to those who need it most. These conclusions are drawn from experiences that are rarely articulated and from stories that are rarely told; and it is in these lay perspectives on housing, health, and inequality that some key ideas about what could and should be different may be found.

References


Ellaway, A., & Macintyre, S. (1998). Does housing tenure predict health in the UK because it exposes people to different levels of housing-related hazards in the home or its surroundings? *Health and Place, 4*, 141–150.


Housing as Health Capital


SUSAN J. SMITH is Professor of Geography at the University of Edinburgh. She has worked on housing and health projects for more than 10 years, and is more generally interested in geographies of inequality and exclusion. Her books include *Housing and Social Policy* (Macmillan, 1990), *Children at Risk?* (Open University Press, 1996), and *Housing for Health* (Longman, 1991). She has published in a range of journals, including *Social Science and Medicine, Policy and Politics, Public Health, Health and Place, Housing Studies*, and the *British Medical Journal*.

DONNA EASTERLOW gained her Ph.D. from the University of Edinburgh, where she is currently a lecturer in Geography. She is interested in geography and public policy. Her work includes an analysis of the effectiveness of medical priority for rehousing in the British public sector, and a study of health and life insurance. She has published in a variety of health and housing journals, including *Public Health, Housing Studies*, and *Health and Place*.

MOIRA MUNRO is Professor of Planning and Housing at Heriot Watt University. She has long-standing interests in housing finance, housing inequality, and the meaning of the home. She has conducted extensive research into the housing aspects of community care, sheltered housing, and the design of homes and has published widely in academic journals, including *Urban Studies, Journal of Social Policy, Policy and Politics*, and *Environment and Planning*. 

KATRINA M. TURNER completed a Ph.D. on teenage pregnancy at Stirling University. Together with Donna Easterlow she played a key role in securing and conducting the household interviews on which this article is based. She is now a research fellow at Glasgow University.