# Placing a housing lens on neighbourhood disadvantage, socioeconomic position and mortality

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Designing effective health interventions requires knowledge of the interplay between context, individual circumstances and health. In this issue of *The Lancet Public Health*, the study by Ana Isabel Ribeiro and colleagues[1] makes a seemingly simple and intuitive finding; that across many people and many settings, neighbourhood deprivation has a stronger effect on the mortality of people with a low educational attainment than people with a higher educational attainment. The results show, both statistically and using proxies, how context and individual opportunity work together to drive an ultimate health outcome: all-cause mortality.

Ribeiro and colleagues[1] make the following notable observations. First, that age-adjusted mortality rates can be theoretically modified by contextual and individual factors, and their interaction with each other. Second, that policies aiming to narrow health inequalities should simultaneously intervene at the individual and community levels. And third, that the amplification of inequalities by people's context (deprivation amplification), and their relative socioeconomic position within an area (relative standing), might explain the social processes underlying contextual and individual determinants of mortality.

To better understand the necessity of this study for public health, and its usefulness for the design of health interventions,[2] it is important to consider that each individual's housing circumstances are different and that housing is simultaneously absolute in its negative effect on population health (eg, exposure to dampness or mould),[3] relative (eg, the negative mental health effects of housing affordability vary by tenure),[4,5] and sits within a neighbourhood and wider housing system context that might amplify or protect against housing disadvantages. People's chances of being exposed to unhealthy housing are greater the lower their income,[6] and disadvantaged neighbourhoods have more poor-quality housing.[7]

Poor housing conditions (ie, cold, damp, mould) can negatively affect health,[8] compounding financial difficulties and, potentially, affecting quality of life. Also, because location is a strong driver of house prices (and rent prices), for a low-income household, home is also likely to be in a disadvantaged area. Often, health services might be less accessible or of a poorer quality—contributing to spatial inequalities,[9] and amplifying the negative health effects of an unhealthy housing environment.

In terms of the social process, identified in the study, of a household's relative standing contributing to worse health outcomes, poor condition housing might stand out in socioeconomically advantaged areas. This distinction might lead to social exclusion and discrimination, or it might lead to more community support from neighbours and health-care providers.

What can be done to intervene to generate better health outcomes for people disadvantaged by their housing circumstances? This study by Ribeiro and colleagues shows the need to understand context before designing health-focused interventions. People living in poor-condition housing in a poor area might benefit most in the long term from place-based initiatives that seek to increase housing quality for everyone (perhaps by setting minimum standards for housing construction and maintenance), whereas people living in poor-condition houses in advantaged areas might benefit from both universal minimum standards and community-focused social inclusion initiatives. Households experiencing both types of disadvantage would also benefit from direct support (either financial or instrumental) to fix and maintain their homes.

The study by Ribeiro and colleagues has some notable limitations. First, the model assumes static populations without agency. However, people often move. Place-based solutions that improve housing and amenity in an area might see property prices rise and lower socioeconomically positioned households displaced elsewhere.[10] Second, the sensitivity analyses suggest that settings with a high spatial segregation had the strongest effects of deprivation. The extent to which people who live in the same area are homogenous varies greatly across contexts. Discrepancies between an individual's social position relative to their neighbour's in an area is a determinant of how much the characteristics of places can affect the health of people within that group. Such variations need to be factored

in policy responses to improve health and reduce health inequalities. Finally, it is imperative to establish the relevant geography that is meaningful to people's health: streets, houses, neighbourhoods, or boundaries defined by a person's social networks. Although postal code and other administrative areas are convenient for research, they are not necessary for people's lives.

The study by Ribeiro and colleagues contributes to our conceptual knowledge, it provides a valuable demonstration of the connectedness of socioeconomic position, area disadvantage, and life expectancy across national contexts. The challenge remains how to operationalise these findings and design interventions that disrupt the contextual and individual differences of people that result in real years of life lost. Context matters, places are dynamic, deprivation is just one dimension of a place, and death rates are amenable to change. With this knowledge comes an obligation to act to reduce socioeconomic inequalities in mortality where possible.

We declare no competing interests.

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